

State of Illinois

Rod R. Blagojevich, Governor

Department of Central Management Services
Bureau of Benefits



Benefit Choice Options



College Insurance Program

Enrollment Period, May 1 – 31, 2008 • Effective July 1, 2008 – June 30, 2009

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

| Health Care Plan Name/Administrator | Toll-Free Telephone Number | TDD / TTY Number | Website 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/stateofillinois |
| OSF HealthPlans | (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 | Administrator's Name and Address | Customer Service Phone Numbers | Website Address |
|--|---|--|-------------------------------|
| Vision Plan Administrator | EyeMed Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111 | (866) 723-0512 (800) 526-0844 (TDD/TTY) | www.eyemedvisioncare.com/stil |
| College Choice Dental Plan (CCDP) Administrator | CompBenefits Group Number 970 P.O. Box 4677 Chicago, IL 60680-4721 | (800) 999-1669 (312) 829-1298 (TDD/TTY) | www.compbenefits.com |
| Health/Dental Plans and the Medicare COB Unit | CMS Group Insurance Division 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208 | (217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY) | www.benefitschoice.il.gov |
| General Eligibility and Enrollment Information | State Universities Retirement System (SURS) P.O. Box 2710 Champaign, IL 61825-2710 | (800) 275-7877 (217) 378-8800 (TDD/TTY) | www.surs.com |

Plan Administrator information continued on inside back cover.

NOTIFICATION OF OTHER GROUP COVERAGE

It is the participant's responsibility to notify the State Universities Retirement System (SURS) of any addition of, or change to, other group insurance coverage during the plan year. The participant must provide their Coordination of Benefits (COB) information to SURS as soon as possible.

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Important Changes For Plan Year 2009 (July 1, 2008 through June 30, 2009)

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

HMO Changes

- Inpatient hospital, including behavioral health, co-payment increases to \$250
- Outpatient surgery co-payment increases to \$150

College Choice Health Plan (CCHP) Changes

- Plan year deductible for a Medicare Primary Participant increases to \$500
- In-network, out-of-pocket maximum (family) is \$2,750
- Out-of-network, out-of-pocket maximum (individual) increases to \$4,400
- Out-of-network, out-of-pocket maximum (family) is \$8,800
- Inpatient hospital deductible, includes transplants, (in-network) is \$200
- Inpatient hospital deductible (out-of-network) increases to \$400
- Inpatient hospital coinsurance (out-of-network) is 60%
- Chiropractic visit (in-network) is 80%
- Chiropractic visit (out-of-network) is 60% of U&C
- Lab and X-ray (out-of-network) is 60% of U&C
- Durable Medical Equipment (out-of-network) is 60% of U&C
- Licensed Ambulatory Surgical Treatment Centers (out-of-network) is 60% of U&C
- Professional and Other Services (in-network) is 80%
- Professional and Other Services (out-of-network) is 60% of U&C
- Prescription co-payments are \$12/\$24/\$48

Open Access Plan (OAP) – administered by HealthLink

There are significant changes within the benefit structure of Tier I, Tier II and Tier III. Refer to page 5 for specific details.

College Choice Dental Plan (CCDP) Changes

- Increase in benefit levels of preventive, diagnostic and some restorative services

BENEFIT CHOICE PERIOD IS MAY 1-31, 2008

The Benefit Choice Period is **May 1 through May 31, 2008** for all Benefit Recipients. Elections will be effective July 1, 2008. The Benefit Choice Period is the **only** time of the year, other than when a qualifying change in status occurs, when 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) – administered by HealthLink
- College Choice Health Plan (CCHP) – administered by CIGNA

See pages 4-7 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 (adding dependent coverage requires documentation)

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 |
|--|---|--------------------------------------|--|----------------------------------|
| Benefit Recipient Managed Care Plans | \$77.24 | \$193.09 | \$239.68 | \$78.96 |
| Dependent Beneficiary Managed Care Plans | \$308.94 | \$772.36 | \$958.70 | \$315.85 |
| Benefit Recipient CCHP Plan | \$88.39 | \$220.97 | \$357.28 | \$90.71 |
| Dependent Beneficiary CCHP Plan | \$353.56 | \$883.89 | \$1,313.35 | \$362.85 |

* 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 inside front cover for contact information.

HMO BENEFITS

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

| HMO Plan Design | |
|--|---|
| Plan year maximum benefit | Unlimited |
| Lifetime maximum benefit | Unlimited |
| Hospital Services | |
| Inpatient hospitalization | 100% after \$250 co-payment per admission |
| Alcohol and substance abuse (maximum number of days determined by the plan) | 100% after \$250 co-payment per admission |
| Psychiatric admission (maximum number of days determined by plan) | 100% after \$250 co-payment per admission |
| Outpatient surgery | 100% after \$150 co-payment |
| Diagnostic lab and x-ray | 100% |
| Emergency room hospital services | 100% after the lesser of \$200 co-payment per visit, or 50% of U&C |
| Professional and Other Services | |
| Physician Office visit (including physical exams and immunizations) | 100% after \$15 co-payment per visit |
| Specialist office visit | 100% after \$15 co-payment per visit |
| Psychiatric care (maximum number of days determined by the plan) | 100% of the cost after a 20% or \$20 co-payment per visit |
| Alcohol and substance abuse care (maximum number of days determined by the plan) | 100% of the cost after a 20% or \$20 co-payment 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 | 100% after \$15 co-payment per visit |

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

OPEN ACCESS PLAN (OAP) BENEFITS

The OAP, administered by HealthLink, provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with pre-determined co-payments. Tier III (out-of-network) offers members flexibility in selecting healthcare 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. Plan participants enrolled in the OAP can mix and match providers. The benefits described below represent the minimum level of coverage available in the OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the plan participant's responsibility to know and follow the specific requirements of the OAP plan. Contact HealthLink for a copy of the SPD.

| Benefit | Tier I 100% Benefit | Tier II 80% Benefit | Tier III (Out-of-Network) 60% Benefit |
|---|---|---|--|
| Plan Year Maximum Benefit | Unlimited | Unlimited | \$1,000,000 |
| Lifetime Maximum Benefit | Unlimited | Unlimited | \$1,000,000 |
| Annual Out-of-Pocket Max Per Individual Enrollee Per Family | \$0 \$0 | \$700 \$1,400 | \$1,700 \$3,600 |
| Annual Plan Deductible (must be satisfied for all services) | \$0 | \$300 per enrollee* | \$400 per enrollee* |
| Hospital Services | | | |
| Inpatient | 100% after \$250 co-payment per admission | 80% of network charges after \$300 co-payment per admission | 60% of U&C after \$400 co-payment per admission |
| Inpatient Psychiatric | 100% after \$250 co-payment per admission, up to 30 days per plan year | 80% of network charges after \$300 co-payment per admission up to 30 days per plan year | 60% of U&C after \$400 co-payment per admission, up to 30 days per plan year |
| Inpatient Alcohol and Substance Abuse | 100% after \$250 co-payment per admission, up to 10 days rehabilitation per plan year | 80% of network charges after \$300 co-payment per admission up to 10 days rehabilitation per plan year | 60% of U&C after \$400 co-payment per admission, up to 10 days rehabilitation per plan year |
| Emergency Room | 100% after \$200 co-payment per visit | 80% of network charges after \$200 co-payment per visit | 60% of U&C after lesser of \$200 co-payment per visit, or 50% of U&C |
| Outpatient Surgery | 100% after \$150 co-payment | 80% of network charges after \$150 co-payment | 60% of U&C after \$150 co-payment |
| Outpatient Psychiatric and Substance Abuse | 100% after \$20 co-payment, up to 30 visits per plan year | 80% of network charges after \$20 co-payment, up to 30 visits per plan year | 60% of U&C after \$20 co-payment, up to 30 visits per plan year |
| Diagnostic Lab and X-ray | 100% | 80% of network charges | 60% of U&C |
| Physician and Other Professional Services | | | |
| Physician Office Visits | 100% after \$15 co-payment | 80% of network charges after \$15 co-payment | 60% of U&C |
| Specialist Office Visits | 100% after \$15 co-payment | 80% of network charges after \$15 co-payment | 60% of U&C |
| Preventive Services, including immunizations, Well Baby care, allergy testing and treatment | 100% after \$15 co-payment | 80% of network charges after \$15 co-payment | Covered under Tier I and Tier II only |
| Other Services | | | |
| Prescription Drugs – Covered through State of Illinois administered plan, Medco | | | |
| | Generic \$10 | Preferred Brand \$20 | Non-Preferred Brand \$40 |
| Durable Medical Equipment | 100% | 80% of network charges | 60% of U&C |
| Skilled Nursing Facility Transplant Coverage | 100% | 80% of network charges | Covered under Tier I and Tier II only |
| Home Health Care | 100% after \$15 co-payment | 80% of network charges after \$15 co-payment | Covered under Tier I and Tier II only |

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

THE COLLEGE CHOICE HEALTH PLAN (CCHP)

CCHP is the medical 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 CCHP network provider. The CCHP has a nationwide network that consists of physicians, hospitals, ancillary providers, pharmacies (Medco retail pharmacy network) and behavioral health services (Magellan behavioral health network).

Notification to Intracorp, the CCHP notification administrator, is required for certain medical services in order to avoid penalties. Refer to pages 54-55 of the 2007 Benefits Handbook, or contact Intracorp at (800) 962-0051, for direction.

Plan participants can access plan benefit and participating 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.

Plan Year Maximums and Deductibles

| | | | | | | | |
|---|---|---------------------------|-------|-------------------------|-------|-----------------------------|-------|
| Lifetime Maximum | \$1,000,000 | | | | | | |
| Plan Year Deductible | \$500 CCHP Primary Participant (Non-Medicare) \$500 Medicare Primary Participant | | | | | | |
| Additional Deductibles* * These are in addition to the plan year deductible. | <table> <tr> <td>Each emergency room visit</td> <td>\$400</td> </tr> <tr> <td>CCHP hospital admission</td> <td>\$200</td> </tr> <tr> <td>Non-CCHP hospital admission</td> <td>\$400</td> </tr> </table> | Each emergency room visit | \$400 | CCHP hospital admission | \$200 | Non-CCHP hospital admission | \$400 |
| Each emergency room visit | \$400 | | | | | | |
| CCHP hospital admission | \$200 | | | | | | |
| Non-CCHP hospital admission | \$400 | | | | | | |

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-CCHP hospital charges. Coinsurance and deductibles apply to one or the other, but not both.

| | |
|--|---|
| General: \$1,200 per individual \$2,750 per family per plan year | Non-CCHP Hospital: \$4,400 per individual \$8,800 per family per plan year |
| The following do not apply toward out-of-pocket maximums: <ul style="list-style-type: none"> • Prescription Drug benefits or co-payments. • Behavioral Health benefits, coinsurance or co-payments. • Notification penalties. • Ineligible charges (amounts over Usual and Customary (U & C) and charges for non-covered services). | |

CCHP - MEDICAL PLAN COVERAGE

| Hospital Services | |
|---|--|
| CCHP Network Hospitals | 80% after annual plan deductible. \$200 per admission deductible. |
| Non-CCHP Hospitals | 60% after annual plan deductible. \$400 per admission deductible. |
| Outpatient Services | |
| Lab/X-ray | 80% of negotiated fee or 60% of U&C, as applicable, after plan deductible. |
| Approved Durable Medical Equipment (DME) and Prosthetics | 80% of negotiated fee or 60% of U&C, as applicable, after plan deductible. |
| Licensed Ambulatory Surgical Treatment Centers | 80% of negotiated fee or 60% of U&C, as applicable, after plan deductible. |
| Professional and Other Services | |
| CCHP Physician Network | 80% of negotiated fee after the annual plan deductible. U&C charges do not apply. |
| Physician and Surgeon Services not included in the CCHP Network | 60% of U&C after the annual plan deductible for inpatient, outpatient and office visits. |
| Chiropractic Services - medical necessity required (limit of 30 visits per plan year) | 80% of negotiated fee or 60% of U&C, as applicable, after plan deductible. |
| Transplant Services | |
| Organ and Tissue Transplants | 80% of negotiated fee after inpatient deductible. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services. |
| Behavioral Health Services | |
| Magellan administers the CCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see page 77 of the 2007 Benefits Handbook or call Magellan at (800) 513-2611. | |

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

DISEASE MANAGEMENT PROGRAM FOR CCHP PLAN PARTICIPANTS Well Aware for Better Health® available through CIGNA by Healthways

CCHP plan participants with certain risk factors indicating **diabetes or cardiac health conditions** may receive an invitation to voluntarily participate in one or both of these disease management programs. These **highly confidential** programs are based upon certain medical criteria and provide:

- Personal healthcare support **7 days a week, 24 hours a day** with access to a team of **registered nurses (RNs) and other clinicians**
- **Wellness tools**, such as reminders of regular health screenings
- **Educational materials** regarding your health condition, including identification of anticipated symptoms and ways to better manage these conditions

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 drugs in three levels: generic, preferred brand and non-preferred brand. Each level has a different co-payment amount.

| PRESCRIPTION DRUG CO-PAYS | | |
|-----------------------------------|-------------------|-----------------|
| | PRESCRIPTION PLAN | |
| | CCHP | All Other Plans |
| Generic | \$12 | \$10 |
| Preferred Brand (Formulary Brand) | \$24 | \$20 |
| Non-Preferred Brand | \$48 | \$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.

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 co-payment.

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

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.**

Health Alliance Illinois, HealthLink OAP and the College Choice Health Plan (CCHP) have prescription benefits administered through the Prescription Benefit Manager (PBM), Medco. See the 2007 Benefits Handbook or the Benefits website for more information.

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/stil.

DENTAL PLAN

College Choice Dental Plan (CCDP): 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). 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.** A \$100 individual plan deductible applies for all services other than those listed as preventive or diagnostic. **The maximum benefit per plan participant per plan year for all dental services, including orthodontic and periodontic, is \$2,000 after the plan year deductible.** The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations.

FY09 DENTAL ENHANCEMENTS

The CCDP reimburses only those services that are listed on the Dental Schedule of Benefits. To view the full schedule, go to the Benefits website at www.benefitschoice.il.gov. Listed services are reimbursed at a pre-determined maximum scheduled amount. Plan participants are responsible for all charges over the scheduled amount and/or the annual maximum benefit. The chart below represents enhancements to the Dental Schedule of Benefits.

| DIAGNOSTIC SERVICES | Maximum Benefit | Code |
|---|-----------------|-------|
| Periodic Oral Examination | \$ 20 | D0120 |
| Limited Oral Evaluation (specific oral health problem) | \$ 20 | D0140 |
| Oral Evaluation for Patient Under 3 Years of Age and Counseling with Primary Care giver | \$ 31 | D0145 |
| Comprehensive Oral Examination- new or established patient | \$ 31 | D0150 |
| Radiographs/Diagnostic Imaging | | |
| Intraoral Complete Series (once in a period of three plan years, including bitewings) | \$ 66 | D0210 |
| Intraoral - Periapical First Film | \$ 14 | D0220 |
| Intraoral - Periapical Each Additional Film | \$ 11 | D0230 |
| Bitewing Single Film | \$ 12 | D0270 |
| Bitewing Two Films | \$ 22 | D0272 |
| Bitewing Three Film | \$ 34 | D0273 |
| Bitewing Four Films | \$ 34 | D0274 |
| Panoramic Film, (once in a period of three plan years) | \$ 55 | D0330 |
| PREVENTIVE SERVICES | | |
| Prophylaxis Adult - Twice each plan year | \$ 45 | D1110 |
| Prophylaxis Child - Twice each plan year | \$ 31 | D1120 |
| Topical Application of Fluoride - Child (including prophylaxis) (once each plan year, covered through age 18 only) | \$ 48 | D1201 |
| Topical Application of Fluoride - Child (not including prophylaxis) (once each plan year, covered through age 18 only) | \$ 19 | D1203 |
| Topical Fluoride Varnish; Therapeutic Application for Moderate to High Carries Risk Patients (once each plan year, covered through age 18 only) .. | \$ 19 | D1206 |
| Sealant - per tooth, covered through age 18 only | \$ 31 | D1351 |
| Space Maintainers (Passive Appliances) | | |
| Fixed Unilateral | \$ 95 | D1510 |
| Fixed Bilateral | \$107 | D1515 |
| Removable Unilateral | \$ 95 | D1520 |
| Removable Bilateral | \$107 | D1525 |
| RESTORATIVE SERVICES | | |
| Amalgam Restorations | | |
| Amalgam One Surface, Primary or Permanent | \$ 52 | D2140 |
| Amalgam Two Surfaces, Primary or Permanent | \$ 74 | D2150 |
| Amalgam Three Surfaces, Primary or Permanent | \$ 85 | D2160 |
| Amalgam Four or More Surfaces, Primary or Permanent | \$ 94 | D2161 |
| Other Restorative Services | | |
| Recent Implant/Abutment Supported Crown | \$ 22 | D6092 |
| Recent Implant/Abutment Supported Fixed Partial Denture | \$ 28 | D6093 |

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 College Insurance Program (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 College Insurance Program and experience a continuous period of 63 days or longer without creditable coverage, 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:

| | |
|--|--|
| For the Medical Plan Administrator and Notification/Medical Case Management: CIGNA HealthCare, Privacy Office P.O. Box 5400 Scranton, PA 18503 800-762-9940 | For Pharmacy Benefits: Medco Health Solutions, Privacy Services Unit P.O. Box 800 Franklin Lakes, NJ 07417 800-987-5237 |
| For Behavioral Health Benefits: Magellan Behavioral Health, Privacy Officer 1301 E. Collins Blvd. Suite 100 Richardson, TX 75081 800-513-2611 | For Dental Plan Benefits: 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**

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 the Benefits 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, Part B and/or Part D 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 in the Benefits 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 the OAP Plan**, check box 2. **If you checked box 2, please indicate the name of the plan and enter the plan carrier code (2 characters).** Carrier codes are listed on page 3. **Enter the provider identifier (6 or 10 characters),** 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.

**College Insurance Program
Dependent Beneficiary Group Insurance Form**



CIP Benefit Recipient Name _____ SSN: _____ - _____ - _____
Initial Enrollment **Benefit Choice** (July 1 effective date) Phone #: () _____ - _____
 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) If 2, 4 or 5 was checked, complete the following and submit a copy of the Medicare card:
 1 Non-Medicare 3 Medicare Ineligible age 65+ Part A (Begin Date) _____ - _____ - _____
 2 Medicare Eligible age 65+ 4 Medicare Disability Part B (Begin Date) _____ - _____ - _____
 5 End Stage Renal Part C (Begin Date) _____ - _____ - _____
 Medicare Number: _____ Part D (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 is required to add a dependent.
 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 Carrier Code (2 characters): _____
 Provider Identifier (6 or 10 characters): _____

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 the Benefits 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 Beneficiary'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, Part B and/or Part D 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. Birth Certificates are required when adding a dependent. The dependent types indicated below require additional documentation.

- 4 - Stepchild: Written documentation from the Benefit Recipient that the child lives with them in a parent-child relationship.
 - 6 - Legal Guardian: A copy of the court decree establishing the Benefit Recipient as legal guardian for a child under 18 years of age.
 - 7 - Adjudicated Child: A copy of the court decree establishing the Benefit Recipient's financial responsibility for the child's health care.
 - 8 - Student: A Dependent Coverage Certification Statement (CMS-138) and verification of full-time student enrollment in an accredited school.
- 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 carrier code (2 characters). Carrier codes are listed on page 3. Enter the provider identifier (6 or 10 characters), 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.

WHO TO CALL FOR INFORMATION...PLAN ADMINISTRATORS

| Plan Component | Contact For: | Administrator's Name and Address | Customer Service Contact Information |
|---|--|---|--|
| College Choice Health Plan (CCHP) Medical Plan Administrator | Medical service information, network providers, claim forms, ID cards, claim filing/resolution and pre-determination of benefits | CIGNA Group Number 2457490 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 | (800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) 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 | Intracorp, Inc. | (800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html |
| Prescription Drug Plan Administrator 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 | Medco Group Number: 1399CD3, 1399CBS, 1399CCF Paper Claims: Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 Mail Order Prescriptions: Medco P.O. Box 30493 Tampa, FL 33630-3493 | (800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com |
| CCHP Behavioral Health Administrator | Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services | Magellan Behavioral Health Group Number 2457490 P.O. Box 2216 Maryland Heights, MO 63043 | (800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com |

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.

**Illinois Department of Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208**

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