



State of Illinois

Department of Central Management Services
Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 – June 20, 2011

College Insurance Program

Effective July 1, 2011 - June 30, 2012

Plan Administrators

Who to contact for information

Plan Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
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	(866) 876-2194	www.bcbsil.com/stateofillinois
PersonalCare HMO	(800) 431-1211	(217) 366-5551	www.personalcare.org
PersonalCare OAP	(800) 431-1211	(217) 366-5551	www.personalcare.org

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	Delta Dental of Illinois Group Number 20242 P.O. Box 5402 Lisle, IL 60532	(800) 323-1743 (800) 526-0844 (TDD/TTY)	http://soi.deltadentalil.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.org

Plan administrator information continued on inside back cover.

Table of Contents

- Benefit Choice Changes for Plan Year 2012** 2
- Other Plan Year 2012 Changes** 3
- Benefit Choice Period** 4
- Coverage and Monthly Premiums** 4
- Managed Care Plans** 5
 - Managed Care Plans in Illinois Counties (Map) 5
 - HMO Benefits 6
 - Open Access Plan (OAP) Benefits 7
- The College Choice Health Plan (CCHP)** 8
- Prescription Drug Benefit** 10
- Vision Plan** 11
- Dental Options** 12
- Behavioral Health Services** 14
- Plan Participants Eligible for Medicare** 15
- Benefit Choice Options Period Election Forms and Instructions** 17
- Plan Administrators** Inside Front and Back Covers

Benefit Choice Changes for Plan Year 2012

(Enrollment Period May 1 – June 20, 2011)

The information below represents changes to the College Insurance Program benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes. **The Benefit Choice Period will be May 1 – June 20, 2011.** All elections will be effective July 1, 2011.

- **Managed Care Contracts** – From July 1, 2011, through September 28, 2011, members may choose from the following carriers: HealthLink OAP, PersonalCare OAP, HMO Illinois, BlueAdvantage HMO, Health Alliance HMO, Health Alliance Illinois, PersonalCare HMO or the Quality Care Health Plan. Additional information regarding coverage choices that will be offered after September 28, 2011, will be provided as soon as it is available.



- **Dental Plan** - Effective July 1, 2011, Delta Dental of Illinois will become the plan administrator of the dental program. The Dental Schedule of Benefits has not changed. Even though Delta Dental offers two provider networks, the Delta Dental PPOSM network and the Delta Dental PremierSM network, you can still utilize any licensed general or specialty dentist, regardless of whether the dentist participates in one of the networks, and receive the benefit shown on the Dental Schedule of Benefits. However, in most cases you can reduce your out-of-pocket expenses by utilizing a network provider. See pages 12 and 13 for more information.

Questions regarding services rendered prior to July 1, 2011, will continue to be handled by CompBenefits at (800) 999-1669.

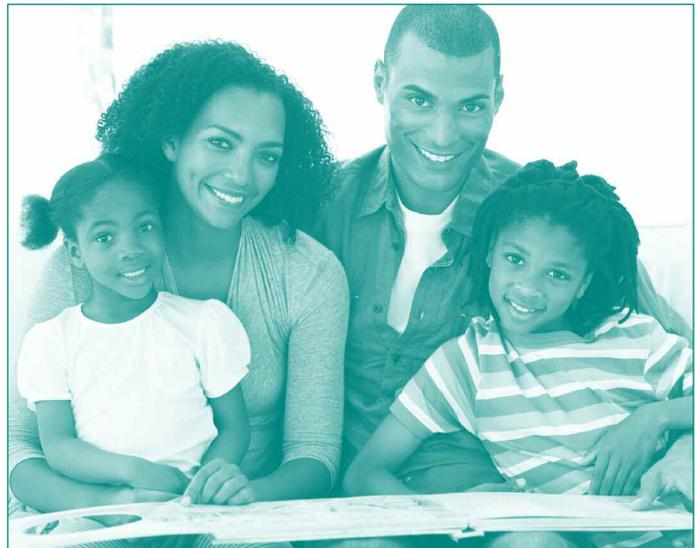
- **Dependent Children** – Effective July 1, 2011, any dependent child (under age 26) will be eligible for health, dental and vision coverage, regardless of student status, marital status or residency. Exception: In accordance with Public Act 95-0958, adult veteran children must live in Illinois in order to be eligible for coverage in the Adult Veteran category. Also, if the adult veteran child is age 26 or older, they must be unmarried. Use the Benefit Choice Enrollment Form on page 19 to enroll a new dependent.

Other Plan Year 2012 Changes

- **Student and Student Leave of Absence** – Effective July 1, 2011, these dependent categories will no longer be available. Dependents enrolled in any of these categories will automatically be reclassified into the “Sponsored Adult Child” category by CMS during the month of August 2011. **Members do not need to take any action regarding this transition.**
- **Civil Union Partners** – Per Public Act 96-1513, the State of Illinois now requires employers to provide coverage for civil union partners and the dependents of civil union partners. June 1, 2011, will begin a 30-day qualifying change in status enrollment period for those members who have a valid Civil Union Partnership Certificate from another state. For members who obtain a Civil Union Partnership Certificate in Illinois, the 30-day qualifying change in status enrollment period will begin upon the issuance of the certificate. Enrollments will be processed in accordance with qualifying change in status rules.

Information and FAQs regarding coverage for civil union partners can be found on the Benefits website. **As the law permitting civil union partner coverage is not effective until June 1, 2011, coverage for civil union partners and their dependents CANNOT be requested during the Benefit Choice Period.**
- **Benefits Handbook** – A new College Insurance Program Benefits Handbook will be released on October 1, 2011. This handbook contains vital information for annuitants and survivors regarding the various benefits offered by the State. The handbook will be available on the Benefits website beginning October 1, 2011.

- **Federal Healthcare** – The following changes are a result of the Patient Protection and Affordable Care Act:
 1. Annual and lifetime maximums have been eliminated.
 2. Residency of a dependent child, except for a dependent child enrolled in the Adult Veteran category, is no longer relevant. Dependent children enrolled in the Adult Veteran category must reside in the State of Illinois to be eligible for coverage.
 3. Marital status of a dependent child under the age of 26 is no longer relevant.
 4. Preventive services are paid at 100%.
- **Prescription Drug Step Therapy (PDST)** – Beginning July 1, 2011, members enrolled in the College Choice Health Plan or one of the self-insured managed care plans will be subject to prescription drug step therapy (PDST). PDST is a program designed to encourage members to select lower cost drugs prior to moving to a higher cost therapeutic equivalent. See page 10 for more information.



Benefit Choice Period May 1 – June 20, 2011

The Benefit Choice Period will be **May 1 – June 20, 2011**, for all Benefit Recipients. Elections will be effective July 1, 2011. 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.

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. State Universities Retirement System (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)

Notification of Other Group Coverage

It is the participant's responsibility to notify 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.

Coverage and Monthly Premiums

Benefit Recipients who enroll in the College Insurance Program (CIP) receive health, prescription, vision, dental and behavioral health benefits. Dependent Beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the Benefit Recipient.

The health insurance plans available to CIP members differ in the benefit levels they provide, the doctors and hospitals that can be accessed

and the out-of-pocket costs. In general, managed care plans, such as health maintenance organizations (HMOs) and the open access plans (OAPs), deliver healthcare through a system of network providers and have a lower monthly premium than the College Choice Health Plan (CCHP). The CCHP allows plan participants to access any provider nationwide; however, enhanced benefits are available when services are received from a CCHP network provider.

Type of Plan	Not Medicare Primary Under Age 26	Not Medicare Primary Age 26-64	Not Medicare Primary Age 65 and Above	Medicare Primary* All Ages
Benefit Recipient Managed Care Plans	\$93.66	\$234.16	\$329.52	\$97.69
Dependent Beneficiary Managed Care Plans	\$374.65	\$936.62	\$1,159.09	\$390.76
Benefit Recipient CCHP Plan	\$103.89	\$259.72	\$428.26	\$102.83
Dependent Beneficiary CCHP Plan	\$415.56	\$1,038.90	\$1,477.91	\$411.33

* 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.

Managed Care Plans in Illinois Counties

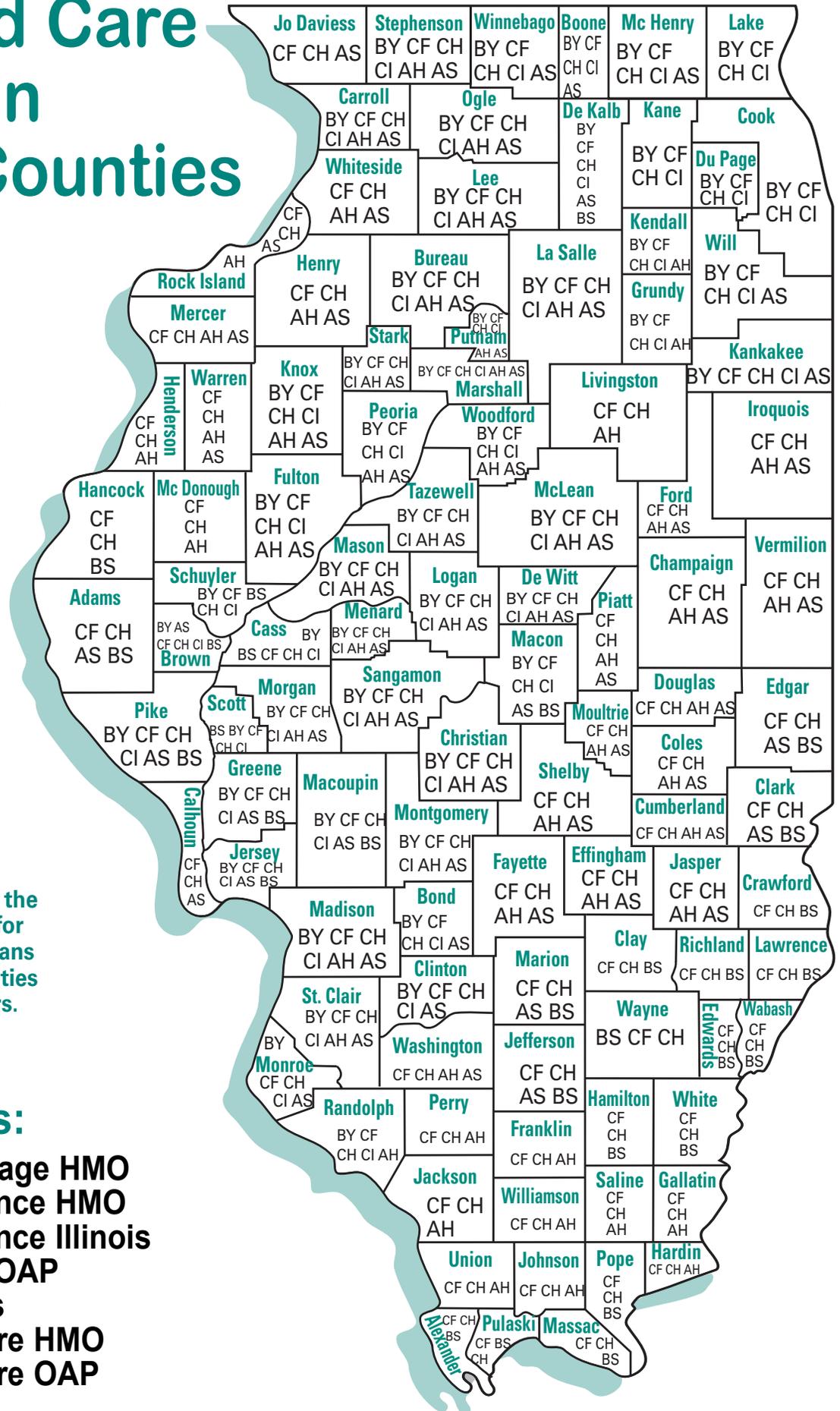
CIP Managed Care Health Plans For Plan Year 2012

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

HMO & OAP Carrier Codes:

- CI = BlueAdvantage HMO
- AH = Health Alliance HMO
- BS = Health Alliance Illinois
- CF = HealthLink OAP
- BY = HMO Illinois
- AS = PersonalCare HMO
- CH = PersonalCare OAP

Note: CCHP available Statewide



HMO Benefits



Plan participants must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the plan participant pays only a copayment. No annual plan deductibles apply. The 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 copayment per admission
Alcohol and substance abuse	100% after \$250 copayment per admission
Psychiatric admission	100% after \$250 copayment per admission
Outpatient surgery	100% after \$200 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after the lesser of \$200 copayment per visit, or 50% of U&C

Professional and Other Services

(Copayment not required for preventive services)

Physician Office visit	100% after \$20 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after \$20 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after \$20 copayment per visit
Prescription drugs (formulary is subject to change during plan year)	\$10 copayment for generic \$24 copayment for preferred brand \$48 copayment for nonpreferred brand
Durable Medical Equipment	80% of network charges
Home Health Care	100% after \$15 copayment per visit

Some HMOs may have benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

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 copayments and/or coinsurance. Tier III (out-of-network) requires higher out-of-pocket costs, but offers members flexibility in selecting healthcare providers. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of healthcare providers. 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 the plan administrator 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	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee	\$0	\$700	\$1,700
Per Family	\$0	\$1,400	\$3,600
Annual Plan Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*

Hospital Services

Inpatient	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Inpatient Psychiatric	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Emergency Room	100% after \$200 copayment per visit	100% after \$200 copayment per visit	100% after \$200 copayment per visit
Outpatient Surgery	100% after \$200 copayment per visit	80% of network charges after \$200 copayment	60% of U&C after \$200 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of U&C

Physician and Other Professional Services (Copayment not required for preventive services)

Physician Office Visits	100% after \$20 copayment	80% of network charges	60% of U&C
Specialist Office Visits	100% after \$20 copayment	80% of network charges	60% of U&C
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after \$20 copayment	80% of network charges	60% of U&C

Other Services

Prescription Drugs – Covered through State of Illinois administered plan			
	Generic \$10	Preferred Brand \$24	Nonpreferred Brand \$48
Durable Medical Equipment	100%	80% of network charges	60% of U&C
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$15 copayment	80% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan copayments, deductibles and amounts over usual and customary (U&C) do not count toward the out-of-pocket maximum.

The College Choice Health Plan (CCHP)

The College Choice Health Plan (CCHP), administered by CIGNA, 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; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a CCHP network provider.

The CCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the CCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. **Note:** The CCHP is separate from the OAP health plans described on page 7.

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

Plan participants can access plan benefit and participating CCHP network information, explanation of benefits (EOB) statements and other valuable health information online. To access website links to plan administrators, visit the Benefits website at www.benefitschoice.il.gov.

Plan Year Maximums and Deductibles

Plan Year Maximum Lifetime Maximum	Unlimited Unlimited								
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 border="0"> <tr> <td>Each emergency room visit</td> <td>\$400</td> </tr> <tr> <td>CCHP hospital admission</td> <td>\$250</td> </tr> <tr> <td>Non-CCHP hospital admission</td> <td>\$500</td> </tr> <tr> <td>Transplant deductible</td> <td>\$250</td> </tr> </table>	Each emergency room visit	\$400	CCHP hospital admission	\$250	Non-CCHP hospital admission	\$500	Transplant deductible	\$250
Each emergency room visit	\$400								
CCHP hospital admission	\$250								
Non-CCHP hospital admission	\$500								
Transplant deductible	\$250								

Out-of-Pocket Maximums

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

In-Network: \$1,500 per individual \$3,000 per family per plan year	Out-of-Network: \$4,500 per individual \$9,000 per family per plan year
--	--

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

- Prescription Drug benefits, deductibles or copayments.
- Notification penalties.
- Ineligible charges (amounts over usual and customary (U & C), charges for noncovered services and charges for services deemed not to be medically necessary).

CCHP - Plan Benefits

Hospital Services

CCHP Hospital Network	<ul style="list-style-type: none"> • \$250 deductible per hospital admission. • 80% after annual plan deductible.
Non-CCHP Hospitals	<ul style="list-style-type: none"> • \$500 deductible per hospital admission. • 60% of U&C after annual plan deductible.

Outpatient Services

Preventive Services, including immunizations	100%
Diagnostic Lab/X-ray	80% in-network, 60% of U&C out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services

Services included in the CCHP Network	80% after the annual plan deductible.
Services not included in the CCHP Network	60% of U&C after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	80% in-network, 60% of U&C out-of-network, after annual plan deductible.

Transplant Services

Organ and Tissue Transplants	80% after \$250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. 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 the 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.

Prescription Drug Benefit

Plan participants enrolled in any CIP health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred brand. Each level has a different copayment amount. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for coordination of benefits (COB) information. CCHP plan participants can receive a 90-day supply of maintenance medication through the Mail Order Program for two copayments.

PRESCRIPTION DRUG COPAYS FOR A 30-DAY SUPPLY

	PRESCRIPTION PLAN	
	CCHP	All Other Plans
Generic	\$12	\$10
Preferred (Formulary) Brand	\$24	\$24
Nonpreferred Brand	\$48	\$48

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

Prescription Drug Step Therapy

Effective July 1, 2011, members who have their prescription drug benefits administered through CCHP or one of the self-insured managed care plans whose prescription benefit manager (PBM) is Medco, will be subject to a coverage tool called prescription drug step therapy (PDST) for specific drugs. PDST requires the member to first try one or more specified drugs to treat a particular condition before the plan will cover another (usually more expensive) drug that their doctor may have prescribed. PDST is intended to reduce costs to both the member and the plan by encouraging the use of medications that are less

expensive but can still treat the member's condition effectively.

Members who are taking a medication that requires step therapy will receive a letter explaining that the plan will not cover that particular medication unless the alternative medication is tried first. The letter will also have directions on how a member's physician may request a coverage review if the physician believes they should take the original medication without trying the alternative medication first.



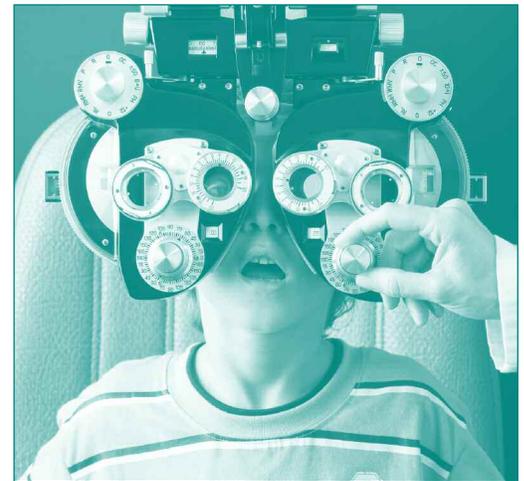
Vision Plan

Vision coverage is provided at no additional cost to Benefit Recipients enrolled in any of the CIP health plans. All Benefit Recipients and enrolled Dependent Beneficiaries 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. Copayments are required.

Service	Network Provider Benefit	Out-of-Network Provider Benefit**
Eye Exam	\$10 copayment	\$20 allowance
Spectacle Lenses* (single, bifocal and trifocal)	\$10 copayment	\$20 allowance for single vision lenses \$30 allowance for bifocal and trifocal lenses
Standard Frames	\$10 copayment (up to \$90 retail frame cost; plan participant responsible for balance over \$90)	\$20 allowance
Contact Lenses (All contact lenses are in lieu of standard frames and spectacle lenses)	\$20 copayment for medically necessary \$50 copayment for elective contact lenses \$70 allowance for all other lenses not mentioned above	\$70 allowance

* Spectacle Lenses: Plan participant pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.

** Out-of-network claims must be filed within one year from the date of service.




EyeMed Vision Care: (866) 723-0512
TDD/TTY: (800) 526-0844
Website: www.eyemedvisioncare.com/stil

Dental Options

All Benefit Recipients and enrolled Dependent Beneficiaries have the same dental benefits available regardless of the health plan selected. Participants may go to any dental provider for services.

Plan participants can access College Choice Dental Plan (CCDP) network information, explanation of benefits (EOB) statements and other valuable information online.

Dental Benefit

The CCDP is a dental plan that offers a comprehensive range of benefits. Effective July 1, 2011, the CCDP will be administered by Delta Dental of Illinois.

The CCDP reimburses only those services listed on the Dental Schedule of Benefits (available on the Benefits website). Listed services are reimbursed at a predetermined maximum scheduled amount. Each plan participant is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as 'Diagnostic' or 'Preventive'. The annual plan deductible is \$100 per participant per plan year. Once the deductible has been met, the plan participant has a maximum annual dental benefit of \$2,000 for all dental services.

Deductible and Plan Year Maximum

Annual Deductible for Preventive Services	N/A
Annual Deductible for All Other Covered Services	\$100
Plan Year Maximum Benefit*	\$2,000

* Orthodontics + all other covered services

Plan participants enrolled in the dental plan can choose any dental provider for services; however, plan participants may pay less out-of-pocket when they receive services from a network dentist. There are two separate networks of dentists that a plan participant may utilize for dental services in addition to out-of-network providers: the Delta Dental PPOSM network and the Delta Dental PremierSM network.

- **The Delta Dental PPO Network:** If you go to a PPO dentist, your out-of-pocket expenses will often be less because these providers accept a reduced PPO fee (less any deductible). If the PPO fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.
- **The Delta Dental Premier Network:** If you go to a Premier dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier fee (less any deductible). If the allowed fee is higher than the amount listed on the Schedule of Benefits, you will be required to pay the difference.
- **Out-of-Network:** If you go to a dentist who does not participate in either the PPO or Premier network, you will receive the same benefits that you currently receive; however, you may have to pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists can bill you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

Provider Payment

If you use a Delta Dental network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit). Network dentists will automatically file the dental claim for their patients. Participants who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the plan participant has with their dentist. **When using an out-of-network dentist, insurance payments will be sent directly to the member and the member is responsible for paying the dentist.**

Dental Options (cont.)

Example of PPO, Premier and Out-of-Network Dentist Payments (*this is a hypothetical example only and assumes all deductibles have been met*).

Delta Dental PPO Dentist*		Delta Dental Premier Dentist*		Out-of-Network Dentist	
Dentist submitted fee	\$1,000	Dentist submitted fee	\$1,000	Dentist submitted fee	\$1,000
PPO allowed fee	\$790	Premier maximum allowed fee	\$900	No negotiated fee	n/a
Schedule of Benefits amount	\$781	Schedule of Benefits amount	\$781	Schedule of Benefits amount	\$781
Your Out-of-Pocket Cost	\$9	Your Out-of-Pocket Cost	\$119	Your Out-of-Pocket Cost	\$219

* When utilizing a PPO or Premier dentist, if the maximum allowed fee is greater than the amount listed on the Schedule of Benefits, the network dentist can bill the member the difference between the two amounts.

Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. The maximum lifetime benefit for child orthodontia is \$1,500. This lifetime maximum is subject to course of treatment limitations (see 'Length of Orthodontia Treatment' chart below).

Members who have children who are currently undergoing orthodontia treatment which began prior to July 1, 2011, should contact their orthodontist's office and request that they submit the original orthodontia treatment plan to Delta Dental for reimbursement purposes. Members who use an out-of-network provider may be required to pay for services up front. Delta Dental will reimburse the member (not the provider) for the insurance portion of the services. Reimbursements will be subject to the claims hold.

Orthodontia Services

Annual Deductible*	\$100
Maximum Lifetime Orthodontia Benefit	\$1,500

* The annual plan year deductible will need to be satisfied unless it was previously satisfied for other dental services incurred during the plan year.

Length of Orthodontia Treatment

The lifetime maximum benefit for child orthodontics is based on the length of treatment. This lifetime maximum applies to each plan participant regardless of the number of courses of treatment.

Length of Treatment	Maximum Benefit
0 - 36 Months	\$1,500
0 - 18 Months	\$1,364
0 - 12 Months	\$780

Prosthodontic Limitations

(Prosthodontics include full dentures, partial dentures and crowns)

- Prosthodontics to replace missing teeth are covered only for teeth that are lost while the plan participant is covered by this plan.
- Multiple procedures are subject to limitations. Please refer to the Dental Schedule of Benefits PRIOR to the start of any procedure to clarify coverage limitations.

 **Delta Dental: (800) 323-1743**
TDD/TTY: (800) 526-0844
Website: <http://soi.deltadentalil.com>

Behavioral Health Services

College Choice Health Plan:

Behavioral health services are now included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Behavioral health services are not subject to separate copayments, limits or other specific provisions. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the College Choice Health Plan (CCHP) benefit schedule on pages 8 and 9 for in-network and out-of-network providers.

Magellan Behavioral Health is the plan administrator for behavioral health services under CCHP. Please contact Magellan for specific benefit information.

Managed Care Plans:

Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules on pages 6 and 7. Please contact the managed care plan for specific benefit information.

Disease Management Programs and Wellness Offerings

Disease Management Programs:

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

Wellness Offerings:

Wellness options and preventive measures are offered and encouraged by CIGNA and the managed care plans. Offerings range from health risk assessments to educational materials and, in some cases, discounts on items such as gym memberships and weight loss programs. These offerings are available to plan participants and are provided to help you take control of your personal health and well-being. Information about the various offerings is available on the plan administrators' websites listed on the inside covers of this book and on the Benefits website.



Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

- Participants age 65 or older
- Participants under age 65 with certain disabilities
- Participants of any age with End-Stage Renal Disease (ESRD)

Medicare has the following parts to help cover specific services:

- **Medicare Part A** (Hospital Insurance): Part A coverage is a premium-free program for participants with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).
- **Medicare Part B** (Outpatient and Medical Insurance): Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for members who are retired or who have lost "current employment status" and are eligible for Medicare.
- **Medicare Part C*** (also known as Medicare Advantage): Part C is insurance that helps pay for a combination of the coverage provided in Medicare Parts A, B and D. An individual must already be enrolled in Medicare Parts A and B in order to enroll into a Medicare Part C plan. Medicare Part C requires a monthly premium contribution.
- **Medicare Part D*** (Prescription Drug Insurance): Medicare Part D coverage requires a monthly premium, unless the participant qualifies for extra-help assistance.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Plan participants may also contact the SSA via the internet at www.socialsecurity.gov to sign up for Medicare Part A.

* The College Insurance Program **does not require** plan participants to choose a Medicare Part C Plan (over the original Medicare Part A and B option) or to enroll in a Medicare Part D prescription drug plan.

College Insurance Program Medicare Requirements

Each plan participant must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a plan participant is eligible for Medicare Part A at a premium-free rate, the plan participant must accept the Medicare Part A coverage.

If the SSA determines that a plan participant is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the plan participant must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the Medicare COB Unit to avoid a financial penalty. Plan participants who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA are not required to enroll into Medicare Parts A or B.

Each plan participant who becomes eligible for Medicare is required to submit a copy of his or her Medicare card to the State Universities Retirement System (SURS).

Plan Participants (Members and Dependents) Eligible for Medicare (cont.)

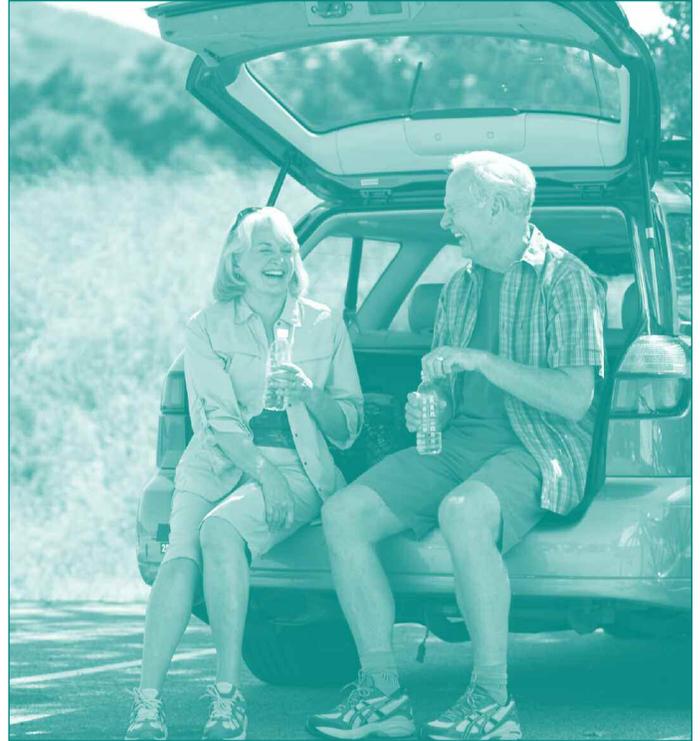
Retirees and Employees without Current Employment Status (and their applicable Dependents)

Members who are retired or who have lost Current Employment Status (such as no longer working due to a disability related leave of absence) and are eligible for Medicare (or have a dependent that becomes eligible for Medicare) due to turning age 65 or due to a disability (under the age of 65) must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the College Insurance Program. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the College Insurance Program and will result in additional out-of-pocket expenditures for health-related claims.**

Survivors (and their applicable Dependents)

Survivors (or their dependents) who become eligible for Medicare due to turning age 65 or due to a disability (under the age of 65) must enroll in the Medicare Program. Medicare is the primary payer for health insurance claims over the College Insurance Program. **Failure to enroll and maintain enrollment in Medicare Parts A and B when Medicare is the primary insurance payer will result in a reduction of benefits under the College Insurance Program and will result in additional out-of-pocket expenditures for health-related claims.**

If you are a survivor enrolled in Medicare Part A only, it is imperative that you contact the Medicare COB Unit to discuss the Medicare requirement.



Plan Participants Eligible for Medicare on the Basis of End-Stage Renal Disease (ESRD):

Plan participants who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding Medicare requirements and to ensure proper calculation of the 30-month coordination of benefit period.

To ensure that benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, plan participants must notify the State of Illinois Medicare COB Unit when they become eligible for Medicare. The Medicare COB Unit can be reached by calling (800) 442-1300 or (217) 782-7007.

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 College Insurance Program (CIP) and to enroll or make coverage changes during the annual Benefit Choice Period. For Benefit Choice Period changes, complete only the sections that you are requesting to change. Be sure to provide your complete name and social security number (SSN). For initial enrollment in CIP outside of the annual Benefit Choice Period, you must complete the entire form. If you are adding a dependent you will also need to complete the Dependent Beneficiary Group Insurance Form.

Check the box for your reason/qualifying event for enrolling in CIP. If you are a Survivor, you must also supply the deceased member's SSN and check the box that indicates your relationship to the Benefit Recipient.

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 be effective July 1st.

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 the Social Security Administration (SSA) stating Medicare ineligibility should accompany this form.

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" section.

The relationship space should be filled with one of the following:

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 – Health Plan

If you are choosing the **College Choice Health Plan (CCHP)**, check box 1; if you are choosing either an **HMO or an OAP Plan**, check box 2. **If you check box 2, please indicate the name of the plan and the plan's carrier code (2 characters).** Carrier codes are listed on the managed care plan map which can be found through the CIP link on the Benefits website at www.benefitschoice.il.gov. **If you are enrolling in an HMO, you must also enter the PCP number or provider identifier (6 - 10 characters),** which can be found in the managed care provider directory of your chosen plan.

SECTION V – Coordination of Benefits

If you are enrolled in another group health or dental plan, you must submit a copy of your health and/or dental card to SURS.

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



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

CIP Benefit Recipient Name _____ SSN _____ - _____ - _____
Phone # () _____ - _____

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

Dependent SSN _____ - _____ - _____ Effective Date of Enrollment _____ - _____ - _____
Last Name _____ First _____ Middle _____
Birthdate (mm/dd/ccyy) _____ - _____ - _____ Sex (M/F) _____ Retirement Date (mm/dd/ccyy) _____ - _____ - _____

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

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

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

Part A (Begin Date) _____ - _____ - _____
Part B (Begin Date) _____ - _____ - _____
Part D (Begin Date) _____ - _____ - _____
Part A Free (Y) _____ (N) _____

Medicare Number _____

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)

Other Addressee Name and Address:

Name _____
Address _____
City _____
State _____ ZIP Code _____ + _____
Country _____
(for foreign address only)

Send Mail to this Address (Y/N) _____

Addressee SSN _____ - _____ - _____
Relationship _____
Date of Relationship _____ - _____ - _____
Send Mail to this Address (Y/N) _____

SECTION IV Relationship (Check One): Supporting documentation is required to add a dependent (see instructions on back).

- | | |
|---|---|
| 1 Spouse <input type="checkbox"/> | 7 Adjudicated Child <input type="checkbox"/> |
| 2 Natural Child <input type="checkbox"/> | 9 Disabled <input type="checkbox"/> |
| 3 Adopted Child <input type="checkbox"/> | 10 Parent <input type="checkbox"/> |
| 4 Stepchild <input type="checkbox"/> | 11 Sponsored Adult Child <input type="checkbox"/> |
| 5 Recognized Child <input type="checkbox"/> | 13 Veteran Adult Child <input type="checkbox"/> |
| 6 Legal Guardian <input type="checkbox"/> | |

Reason for Enrollment (check one)

- | | | |
|--|--|---|
| <input type="checkbox"/> Benefit Recipient Application for Annuity | <input type="checkbox"/> Dependent Beneficiary Turns 65 | <input type="checkbox"/> Benefit Choice |
| <input type="checkbox"/> Coverage Terminated by Employer | <input type="checkbox"/> Dependent Beneficiary Eligible for Medicare | |

SECTION V Health Plan:

(Check plan of Benefit Recipient)
College Choice Health Plan (CCHP)
HMO or OAP Plan

If you selected a managed care plan, you must complete the following:

Plan Name _____
Plan Carrier Code (2 characters - see map) _____

If you elected an HMO, also complete the PCP/Provider Identifier below:

PCP/Provider Identifier (6 - 10 characters) _____

SECTION VI Coordination of Benefits:

If you are enrolled in another group health or dental plan you must provide a copy of your health and/or dental card to SURS.

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 the initial enrollment of a Dependent Beneficiary into the College Insurance Program (CIP) and to enroll or make coverage changes during the annual Benefit Choice Period. For initial enrollment outside the Benefit Choice Period, you must complete the entire form. For Benefit Choice Period changes, complete only the sections that you are requesting to change. Be sure to provide your (i.e., the person receiving the annuity) complete name and social security number (SSN).

SECTION I - Dependent Beneficiary's Personal Information

Dependent SSN: Enter the Dependent Beneficiary's 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 Beneficiary'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 Beneficiary is retired, enter the retirement date.

SECTION II - Dependent Beneficiary'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 the Social Security Administration (SSA) stating the Dependent Beneficiary's ineligibility should accompany this form.

SECTION III - Dependent Beneficiary'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" section. The relationship space should be filled with one of the following:

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 Beneficiary's Relationship

Check the box that reflects the relationship of the Dependent Beneficiary to the Benefit Recipient. Birth certificates and the dependent's SSN are required to add a dependent. The dependent types indicated below require additional documentation:

- 4 Stepchild/Child of Civil Union Partner:** Marriage certificate indicating that the member is married to, or in a civil union partnership with, the child's parent.
- 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 healthcare.
- 13 Veteran Adult Child:** Proof of Illinois residency and a Veterans' Affairs Release Form (DD-214) stating the date the adult child was released from service (or equivalent).

Check the box that reflects the reason for enrolling your dependent.

SECTION V - Health Plan

Dependents must be enrolled in the same plan as the Benefit Recipient. If you are choosing the **College Choice Health Plan (CCHP)**, check box 1; if you are choosing an **HMO or an OAP Plan**, check box 2. **If you check box 2, please indicate the name of the plan and the plan's carrier code (2 characters).** Carrier codes are listed on the managed care plan map which can be found through the CIP link on the Benefits website at www.benefitschoice.il.gov. **If you are enrolling your dependent in an HMO, enter the PCP number or provider identifier (6 - 10 characters),** which can be found in the managed care provider directory of your chosen plan. *Enrolling in a health plan automatically enrolls your dependent in the dental and vision plans.*

SECTION VI - Dependent Beneficiary's Coordination of Benefits

If you are enrolled in another group health or dental plan you must submit a copy of your other health and/or dental insurance card to SURS.

Plan Administrators

Who to call for information

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 predetermination of benefits	CIGNA Group Number 2457490 CIGNA HealthCare P.O. Box 182223 Chattanooga, TN 37422-7223	(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 Noncompliance 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) PersonalCare OAP (1399CCH) HealthLink OAP (1399CCF) Health Alliance Illinois (1399CBS)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Medco Group Number: 1399CD3, 1399CCH, 1399CCF, 1399CBS 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**

**Printed by the authority of the State of Illinois
(CMS-BEN2002-02-1,000-05/11)
Printed on recycled paper**

