



STATE OF ILLINOIS
Department of Central
Management Services
Bureau of Benefits

Benefit Choice

Discover Your Options

Benefit Choice Period • May 1-31, 2018
College Insurance Program
Effective July 1, 2018

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ONLINE ENROLLMENT PLATFORM

Making benefit elections is simple through the MyBenefits website. Follow these steps to register.

1. Log on to **MyBenefits.illinois.gov**.
2. In the top right corner of the home page, click **Login**.
3. Enter your login ID and password. If you are logging in for the first time, click Register in the bottom right corner of the login box and follow the prompts. You will need to provide your name as printed on the Benefit Choice Period materials mailed to your home.
4. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles or using the decision support tool.
5. After exploring your benefit options and determining which benefits you would like to elect, follow the prompts on the welcome page.

Contact MyBenefits Service Center (toll-free) 844-251-1777 or 844-251-1778 (TDD/TTY) with questions about navigating the MyBenefits website or how to elect benefits. Representatives are available Monday – Friday, 8:00 AM – 6:00 PM CT.

WHAT YOU NEED TO DO

1. Go to MyBenefits.illinois.gov to review your benefit options.
2. Choose the benefits you'd like to elect on the MyBenefits website May 1-31, 2018.
3. Consider going paperless. Provide your email address on the MyBenefits website to receive quick responses and notifications through electronic communications.
4. Take advantage of your new benefits which will become effective July 1, 2018.

MARK YOUR CALENDAR

Benefit Choice Period

Elect Your Benefits May 1-31, 2018!

TAKE ACTION! Read about your benefits here, and choose your coverage for the coming year.

What is Changing

The only change to the College Insurance Program (CIP) for FY2019 is your monthly contributions.

What is Not Changing

The MyBenefits online enrollment platform, launched last year, will continue to be of service to all of our members. A simplified plan comparison and election process is provided through online enrollment at MyBenefits.illinois.gov or by calling the MyBenefits Service Center (toll-free) 844-251-1777.

Plan Administrators

Plan administrators will remain the same for all healthcare plans including health, dental, vision, behavioral health, and prescription drugs.

Health Plan Options

There will be no changes to your health plan options this Benefit Choice Period. **If you wish to keep your coverage, no action is needed. If you wish to change your plan or carrier, go online at MyBenefits.illinois.gov.**



Health

The College Insurance Program (CIP) offers comprehensive health plan options, all of which include prescription drug, behavioral health, dental, and vision coverage.

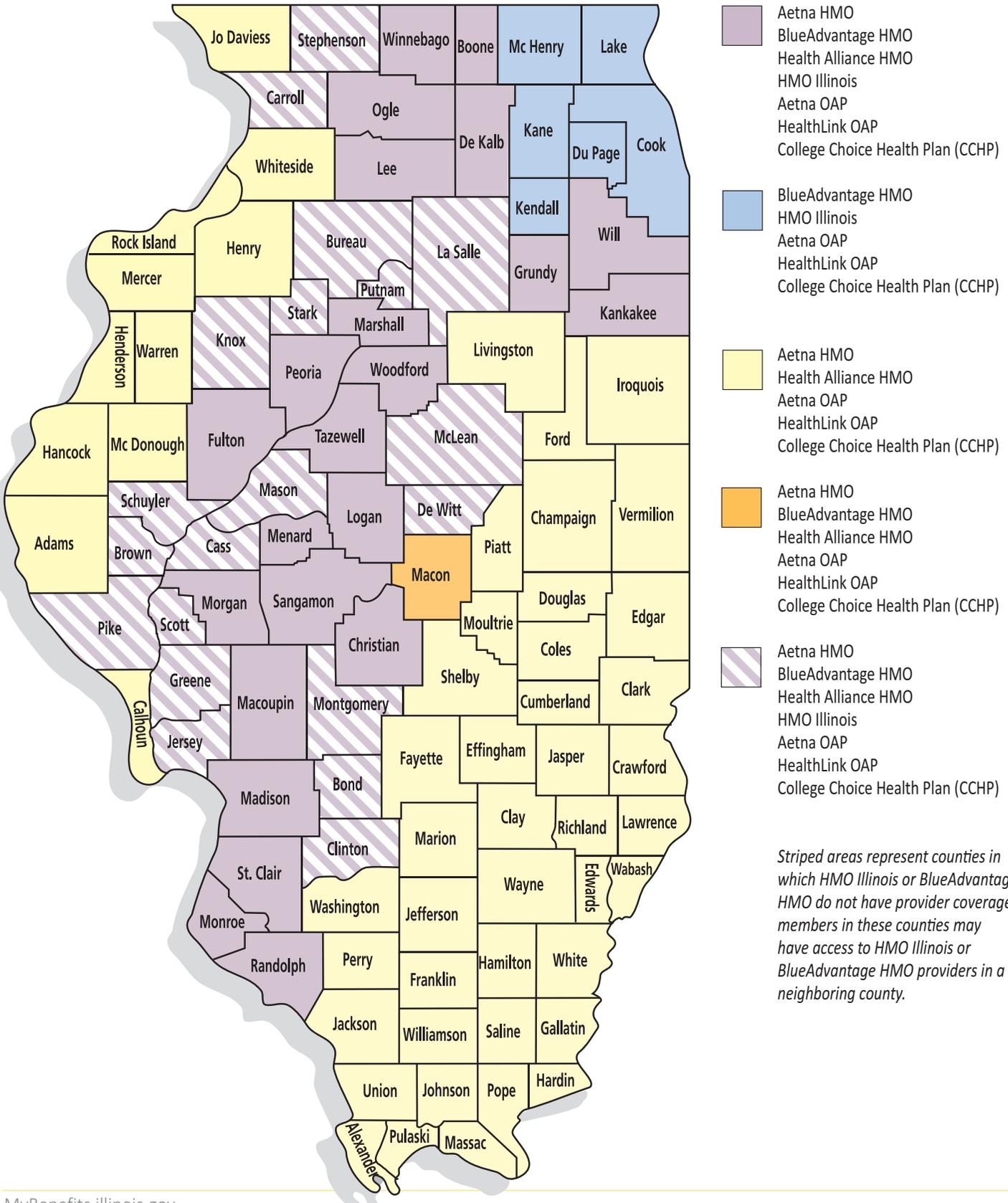
Consider your health needs as you select between CCHP, HMO, and OAP plans.

- College Choice Health Plan (CCHP) benefit recipients may choose any physician or hospital for medical services; however, benefit recipients receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a CCHP in-network provider. CCHP has a nationwide network of providers through Aetna for medical services, CVS/caremark for prescription drug benefits, and Magellan Health Services for behavioral health services.
- Health Maintenance Organizations (HMO) members are required to stay within the health plan provider network. No out-of-network services are available. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization.
- Open Access Plans (OAP) members will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted.
 - Tier I offers a managed care network which provides enhanced benefits and operates similar to an HMO.
 - Tier II offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
 - Tier III covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involves higher out-of-pocket costs. Furthermore, members who use out-of-network providers will be responsible for any amount that is more than the charges allowed by the plan for services (allowable charges), which could result in substantial out-of-pocket costs.

Members enrolled in an OAP can mix and match providers and tiers.

What is Available in Your Area in FY19

Review the following map and charts to compare plans. Then, review your monthly contributions to determine which plan is best for you.





YOUR PLAN OPTIONS: A HIGH LEVEL COMPARISON

See page 8
for monthly
contributions.

Additional health plan or prescription drug information can be viewed and compared online through the MyBenefits website at MyBenefits.illinois.gov. Click the Health Plan tile on the home page.

HMO Administrators

- Aetna HMO
- BlueAdvantage HMO
- Health Alliance HMO
- HMO Illinois

OAP Administrators

- Aetna OAP
- HealthLink OAP
- *Prescription Drug Coverage through CVS/caremark*

CCHP Administrators

- College Choice Health Plan (Aetna)
- *Prescription Drug Coverage through CVS/caremark*
- *Behavioral Health Services through Magellan Health Services*

Benefits are outlined in the plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the plan. Contact the plan administrator for a copy of the SPD.

HMO Benefits

Benefit recipients 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 benefit recipient 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 benefit recipient's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan administrator 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 per visit
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after \$200 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after \$30 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after \$30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after \$30 copayment per visit
Prescription drugs (30-day supply) (formulary is subject to change during plan year)	\$12 copayment for generic \$24 copayment for preferred brand \$48 copayment for nonpreferred brand \$96 copayment for specialty
Durable Medical Equipment	80%
Home Health Care	100% after \$30 copayment per visit

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

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the benefit recipient'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 Per Family	\$6,600 (includes eligible charges from Tier I and Tier II combined) \$13,200 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
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 allowable charges after \$400 copayment per admission
Inpatient Psychiatric	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of allowable charges 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 allowable charges 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 allowable charges after \$200 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of allowable charges
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after \$30 copayment	80% of network charges	60% of allowable charges
Specialist Office Visits	100% after \$30 copayment	80% of network charges	60% of allowable charges
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 \$30 copayment	80% of network charges	60% of allowable charges
Other Services			
Prescription Drugs – (30 day supply)			
Generic \$12 Preferred Brand \$24 Nonpreferred Brand \$48 Specialty \$96			
Durable Medical Equipment	80% of network charges	80% of network charges	60% of allowable charges
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 \$30 copayment	80% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your annual out-of-pocket maximum; this varies by plan and geographic region.

College Choice Health Plan (CCHP) Benefits - Aetna

Plan Year Maximums and Deductibles			
Plan Year Maximum	Unlimited		
Lifetime Maximum	Unlimited		
Plan Year Deductible	\$750 per benefit recipient		
Additional Deductibles*	Each emergency room visit	\$400	
	CCHP hospital admission	\$250	
	Non-CCHP hospital admission	\$500	
	Transplant deductible	\$250	
Out-of-Pocket Maximum Limits			
In-Network Individual \$1,500	In-Network Family \$3,000	Out-of-Network Individual \$4,500	Out-of-Network Family \$9,000
Hospital Services			
CCHP Hospital Network	\$250 deductible per hospital admission. 80% after the annual plan deductible.		
Non- CCHP Hospitals	\$500 deductible per hospital admission. 60% of allowable charges after the annual plan deductible.		
Outpatient Services			
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.		
Diagnostic Lab/X-ray	80% in-network, 60% of allowable charges out-of-network, after the 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 allowable charges 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 allowable charges, after the 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, Aetna. To assure coverage, the transplant candidate must contact Aetna prior to beginning evaluation services.		
Prescription Drugs			
Copayments (30-day supply)	Generic	\$12.50	
	Preferred Brand	\$25.00	
	Nonpreferred Brand	\$50.00	
	Specialty	\$100.00	

* These are in addition to the plan year deductible.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your annual out-of-pocket maximum; this varies by plan and geographic region.

Monthly Contributions

The College Insurance Program (CIP) shares the cost of health coverage with you. While CIP covers the majority of the cost, you must make monthly contributions based upon the health plan you select.

Type of Participant	Type of Plan	Not Medicare Primary	Not Medicare Primary	Not Medicare Primary	Medicare Primary*
		Under Age 26	Age 26-64	Age 65 and Above	All Ages
Benefit Recipient	Managed Care Plan (OAP and HMO)	\$119.60	\$299.01	\$418.58	\$117.52
	College Choice Health Plan	\$134.16	\$335.39	\$409.19	\$106.30
Dependent Beneficiary	Managed Care Plan (OAP and HMO)	\$478.41	\$1,196.04	\$1,674.31	\$470.08
	College Choice Health Plan	\$536.63	\$1,341.56	\$1,636.77	\$425.19

This rate applies to benefit recipients enrolled in Medicare Part A only and whose Part B benefits are reduced. 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.

Terminating CIP Coverage

To terminate coverage at any time, contact the MyBenefits Service Center by calling (toll-free) 844-251-1777. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit recipients and dependent beneficiaries who terminate from CIP may re-enroll only upon turning age 65, upon becoming eligible for Medicare or if coverage is involuntarily terminated by a former plan.

Enrollment Opportunities

After the Benefit Choice Period ends, you will only be able to change your benefits if you have an enrollment opportunity.

You must report an enrollment opportunity on the MyBenefits website within 30 days of the event to be eligible to make benefit changes. Also note that it is required to report important events to the MyBenefits Service Center, including a change in Medicare status, marriage or divorce. To report a financial or medical power of attorney, contact your retirement system.

Transition of Care after Health Plan Change

Benefit recipients and their dependents who elect to change health plans and are then hospitalized prior to July 1 and discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Benefit recipients or dependents who are involved in an ongoing course of treatment or have entered the third trimester of pregnancy should contact their new plan administrator before July 1 to coordinate the transition of services for treatment.

College Insurance Program Medicare Requirements

Each benefit recipient must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning age 65. If the SSA determines that a benefit recipient is eligible for Medicare Part A at a premium-free rate, CIP requires that the benefit recipient enroll in Medicare Parts A and B. Once enrolled, the benefit recipient is required to send a front side copy of the Medicare identification card to the State of Illinois Medicare COB Unit.

If the SSA determines that a benefit recipient 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 benefit recipient must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty. Benefit recipients who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA, are not required to enroll into Medicare.

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug Program

The State of Illinois offers retirees, annuitants and survivors a healthcare program referred to as the TRAIL. This program provides eligible members and their covered dependents comprehensive medical and prescription drug coverage through CIP-sponsored Medicare Advantage Prescription Drug plans. In order to be eligible for the TRAIL MAPD program, a member (and all covered dependents) must be enrolled in Medicare Parts A and B and be a resident of the United States (or a US territory). The Department of Central Management Services (CMS) will notify all eligible members by mail prior to the start of the TRAIL Open Enrollment Period this fall. The TRAIL Open Enrollment Period runs from the middle of October through the middle of November each year. All elections made during the TRAIL Open Enrollment Period will be effective January 1st. **All newly eligible members must enroll** into a CIP-sponsored TRAIL plan or opt out of their TRIP-sponsored insurance coverage during the fall open enrollment period. Members already enrolled in a TRAIL Medicare Advantage Prescription Drug Plan are not required to make changes.

For more information regarding the Medicare Advantage Prescription Drug 'TRAIL' Program, go to MyBenefits.illinois.gov.



State of Illinois
Medicare COB Unit
PO Box 19208
Springfield, IL 62794-9208
Fax: 217-557-3973



Dental

CIP's College Choice Dental Plan (CCDP) offers a comprehensive range of benefits and is available to all benefit recipients. The plan is administered by Delta Dental of Illinois. You can find the Dental Schedule of Benefits on the MyBenefits website.

The dental plan has an annual plan deductible. Once the deductible has been met, each benefit recipient is subject to a maximum dental benefit, including orthodontia, for both in-network and out-of-network providers. The maximum lifetime benefit for child orthodontia is \$1,500 and is subject to course of treatment limitations.

Deductible and Plan Year Maximum	
Annual deductible for preventive services	N/A
Annual deductible for all other covered services	\$100
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
Plan year maximum benefit	\$2,000

It is strongly recommended that plan members obtain a pretreatment estimate through Delta Dental for any service over \$200. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs.

Vision

Vision coverage is provided at no cost to all benefit recipients enrolled in a CIP health plan.

All enrolled benefit recipients and dependents receive 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	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	\$10 copayment	\$20 allowance	Once every 24 months
Spectacle Lenses* (single, bifocal and trifocal)	\$10 copayment	\$20 allowance for single vision lenses \$30 allowance for bifocal and trifocal lenses	Once every 24 months
Standard Frames	\$10 copayment (up to \$90 retail frame cost; benefit recipient responsible for balance over \$90)	\$20 allowance	Once every 24 months
Contact Lenses (All contact lenses are in lieu of spectacle lenses)	\$20 copayment for medically necessary \$50 copayment for elective contact lenses \$70 allowance for all other lenses not mentioned above	\$70 allowance	Once every 24 months

* Spectacle Lenses: Member pays any and all optional lens enhancement charges. In-network providers may offer additional discounts on lens enhancements and multiple pair purchase.

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





Wellness

CIP offers wellness programs to help benefit recipients lead better, healthier, and more satisfying lives. The following programs focus on improving lifestyle choices, including eating healthier, being more physically active, managing stress, and avoiding, stabilizing, or improving chronic health problems. Check out the following programs and consider which may be right for you.

Disease Management

Disease Management Programs target and assist those identified as having certain risk factors for chronic conditions, like diabetes and cardiac health. If you have been identified as having risk factors and meet the appropriate medical criteria, you may be contacted by your health plan administrator to participate in one of these highly confidential programs.

Behavioral Health Services

CIP recognizes that the holistic health of their benefit recipients encompasses more than physical health, and offers behavioral health services automatically to those enrolled in a CIP health plan.

If you are enrolled in the CCHP health plan, contact Magellan Health Services (see page 14). If you are enrolled in an HMO or OAP health plan, contact your plan administrator.

WHAT YOU CAN DO

- 1. Get annual preventive checkups and health screenings.** Your health plan covers many preventive services at no cost to you.
- 2. Know your numbers.** Get biometric screenings from your doctor during your annual physical – quick and easy tests that measure your blood pressure, pulse rate, blood glucose, total cholesterol, and body mass index.
- 3. Take a Health Risk Assessment (HRA)** through your health plan administrator’s website – a confidential assessment with health-related questions that, once completed, suggests a personal action plan to improve your health. Results are most accurate when combined with a biometric screening.

Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment Customer Service	MyBenefits – Morneau Shepell 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602	844-251-1777 844-251-1778 (TDD/TTY)	MyBenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285657) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	Aetna OAP (Group Number 285653) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	College Choice Health Plan (CCHP) - Aetna PPO (Group Number 285662) PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY)	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06803) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
	Health Alliance Medical Plans (Group Number 00810A) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY)	healthalliance.org/ stateofillinois
	HealthLink OAP (Group Number 160003) PO Box 411580, St. Louis, MO 63134	800-624-2356 800-624-2356 ext. 6280 (TDD/TTY)	healthlink.com/illinois_ index.asp
	HMO Illinois (Group Number H06803) PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
Prescription Drug Plan	CVS/caremark (for CCHP or OAP Plans) Group Numbers: (CCHP 1399CD3) (Aetna OAP 1399CCH) (HealthLink OAP 1399CCF) Paper Claims: CVS/caremark PO Box 52136, Phoenix, AZ 85072-2136 Mail Order Rx: CVS/caremark PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims PO Box 8504, Mason, OH 45040-7111	866-723-0512 800-526-0844 (TDD/TTY)	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20242) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
Behavioral Health	Magellan Health Services PO Box 2216, Maryland Heights, MO 63043	800-513-2611 (nationwide) 800-526-0844 (TDD/TTY)	magellanassist.com
State Universities Retirement System	1901 Fox Drive PO Box 2710, Champaign, IL 61825-2710	800-275-7877 800-526-0844 (TDD/TTY)	surs.org

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug information for CIP Medicare-eligible Plan Participants

This Notice confirms that the College Insurance Program (CIP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through 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.

Because your existing coverage is 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 coverage through CIP 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 choose to drop your CIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your CIP coverage ends.

If you keep your existing group coverage through CIP, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll in a Medicare prescription drug plan may need to provide a copy of the Notice of Creditable Coverage to enroll in the Medicare prescription plan without a financial penalty. Participants may obtain a Benefits Confirmation Statement as a Notice of Creditable Coverage by contacting the MyBenefits Service Center (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY).

Summary of Benefits and Coverage (SBC) and Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The summary is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in coverage, or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All CIP health plan SBCs, along with the glossary, are available on MyBenefits.illinois.gov.

Notice of Privacy Practices

The Notice of Privacy Practices will be updated on the MyBenefits website, effective July 1, 2018. 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 by the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at MyBenefits.illinois.gov.



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