



# Group Health Benefit Benefits Handbook

**IMPORTANT**

*DO NOT THROW AWAY*

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# Table of Contents

SECTION I. INTRODUCTION.....	1
A. General Overview .....	1
B. Benefit Plan Options in Brief.....	2
C. Contact Information .....	2
SECTION II. ELIGIBILITY REQUIREMENTS.....	3
A. Annuitants.....	3
B. Maintaining Coverage.....	5
C. Termination of Coverage .....	6
D. Family Coverage – Dependents .....	7
E. Making Enrollment/Coverage Changes.....	9
F. Survivors.....	9
G. Benefit Eligibility/Enrollment Summary.....	10
SECTION III. COBRA CONTINUATION COVERAGE .....	11
A. COBRA Continuation Coverage in General .....	11
B. Qualifying Events.....	12
C. Electing COBRA Continuation Coverage .....	13
D. When COBRA Continuation Coverage Ends .....	13
SECTION IV. BENEFIT PLAN OVERVIEW .....	15
A. CHOOSING THE RIGHT PLAN FOR YOU.....	15
B. DETAILED INFORMATION FOR EACH PLAN.....	15
C. PRESCRIPTION DRUG BENEFITS .....	16
D. Important Notices.....	17
SECTION V. COORDINATION OF BENEFITS SECTION .....	18
SECTION VI. GLOSSARY .....	19

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## SECTION I. INTRODUCTION

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### A. General Overview

The County Employees' and Officers' Annuity and Benefit Fund of Cook County, Illinois (the "**County Fund**") and the Forest Preserve District Employees' Annuity and Benefit Fund of Cook County, Illinois (the "Forest Preserve **District Fund**", together with the County Fund, the "**Fund**") currently offers a group health benefit (the "**Group Health Benefit**" or "**Plan**") to annuitants and their eligible family members. The summary of benefits, which follows, is intended only as a general description of the current benefits we offer as of January 1, 2009.

The goal of this Handbook is to present and explain benefits and the related enrollment and eligibility requirements in language that is easy to understand. However, sometimes terms that are specific to group health benefits must be used where commonly used language could not. These terms are uppercased throughout this Handbook and are listed alphabetically and defined in the **Glossary** located at the back of this Handbook.

Please read the information in this Handbook carefully so you will have an understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Fund (see **Contact Information** on page 2).

The Fund has contracted with insurance providers for each of the plans comprising the Group Health Benefit. The **Claim Administrator** (see Glossary) for each plan is responsible for providing each covered individual with a Certificate/Booklet summarizing the benefit coverage, including details concerning covered services, claim filing procedures, etc. Contact the Claim Administrator for a copy of such Certificate/Booklet (see **Contact Information** on page 2). To the extent there is any conflict with this Handbook, the terms of the Certificate/Booklet will control.

## B. Benefit Plan Options in Brief

Eligible Persons may choose from the following plan options based on whether such individuals are a “Non-Medicare Eligible Person” or a “Medicare Eligible Person” (see *Glossary*):

A “Non-Medicare Eligible Person” may enroll in any one of the below group health plans:	A “Medicare Eligible Person” may enroll in any one of the below group health plans.**
BlueCross BlueShield PPO with CVS/Caremark	BlueCross BlueShield Comprehensive Major Medical Plan with CVS/Caremark
HMO Illinois – BlueCross BlueShield with CVS/Caremark	HMO Illinois – BlueCross BlueShield with CVS/Caremark
Unicare HMO with CVS/Caremark	Unicare HMO with CVS/Caremark

**\*\* IMPORTANT NOTE: If an individual becomes eligible for Medicare after coverage commences, that individual will be automatically enrolled in the corresponding Medicare group health plan as of the Medicare eligibility date. You must enroll into Medicare Part A & B if eligible – Do Not enroll into Part D if electing this Group Health Benefit.**

## C. Contact Information

Health Plan Contact Information		
Fund	<p style="text-align: center;"><b><u>Office Address:</u></b>            Cook County Pension Fund            33 N. Dearborn, 10 Floor            Chicago, IL 60602            312.603.1200</p>	
BlueCross BlueShield PPO	800.772-6895	<a href="http://www.bcbsil.com/member">www.bcbsil.com/member</a>
BlueCross BlueShield CMM	800.997.9285	<a href="http://www.bcbsil.com/member">www.bcbsil.com/member</a>
HMO Illinois– BlueCross BlueShield	800.997.9285	<a href="http://www.bcbsil.com/member">www.bcbsil.com/member</a>
UniCare HMO	888.234.8855	<a href="http://www.unicare.com">www.unicare.com</a>
CVS/Caremark– Pharmacy Benefits Manager	888.752.7231	<a href="http://www.caremark.com">www.caremark.com</a>

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## SECTION II. ELIGIBILITY REQUIREMENTS

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This Section contains benefit eligibility information, which applies to ***all*** benefit plan options.

Please note that if you are an Annuitant and have enrolled in the Plan, you may also choose to enroll and cover eligible family members/dependents.

### A. Annuitants

#### 1. *Initial Eligibility*

To be eligible for benefits under the Group Health Benefit, you must be an “Annuitant” as defined in Section 9-239 of the Illinois Pension Code [40 ILCS 5/9-239] and you must have been last employed with Cook County or the Forest Preserve District.

If you choose to elect COBRA continuation coverage under the County’s active group health plan, you will be eligible to enroll in this Plan Option after such COBRA continuation coverage terminates.

#### 2. *Enrollment*

You must take all of the steps listed below to enroll in the Plan before your coverage can begin.

The enrollment steps for coverage under this Plan must be taken when you are eligible and applying for an annuity from the Fund. There is no formal initial enrollment period.

***Enrollment Steps:*** To enroll for Plan coverage, you must:

- Meet the *Initial Eligibility* requirements for Annuitants described above.
- File a completed annuity application with the Fund and have the application approved by the Retirement Board.
- File a completed Plan enrollment form with the Fund.

Your coverage will become effective on the first day of the month following your completion of all the enrollment steps described above.

#### 3. *Military Service*

If you are on active duty with the United States armed forces, you will still be eligible for coverage under the Plan, provided that you meet the eligibility requirements described above.

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4. ***Medicare Eligibility***

Determination of an Eligible Person actual eligibility for Medicare is made by the Social Security Administration (SSA). The Eligible Person must submit a copy of this determination to the Fund, so we may adjust coverage accordingly.

If an enrolled Eligible Person does not contact the Fund prior to the month in which such individual turns age 65, such individual will be assumed as eligible for Medicare Part A and B. As such, the individual will be moved to the Medicare plan that corresponds to the existing coverage and the correct reduced premium will apply.

Enrollment in a Medicare Plan will become effective on the first day of the month on or next following the date the Eligible Person becomes eligible for Medicare.

5. ***Medicare Part D Enrollment***

If you enroll in a Medicare Prescription Drug Plan (Medicare Part D), you will:

- Not be eligible to enroll in the Plan.

*OR*

- Lose Plan coverage if you are already enrolled.

6. ***Age 65 & Over***

a) Medicare Ineligible

If an Annuitant is ineligible for premium-free Medicare Part A, he or she must provide written certification from the SSA that he or she is ineligible for premium-free Part A based on their work history or the work history of any current or former spouse upon turning age 65. The Annuitant is not required to purchase Medicare Part B if ineligible for premium-free Medicare Part A.

b) Medicare Eligible

Eligibility for Medicare benefits begins when a covered individual turns age 65 or is disabled and eligible for Medicare.

Effective January 1, 2010 all Medicare eligible Annuitants and their Dependents enrolled in the Group Health Benefit will be required to enroll into Medicare Part B. The Fund will place all Medicare eligible Annuitants and Dependents into the appropriate Group Health Benefit, regardless of whether an election into Medicare Part B is made, and the claims administrator will process claims accordingly.

The Fund will notify all potential Medicare eligible Annuitants and Dependents of the procedures and documentation required 90 days prior to the month in which they turn age 65.

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## B. Maintaining Coverage

### 1. *Self-Contributions (Premiums)*

You are required to make monthly self-contributions to maintain coverage under the Plan.

**Amount:** The amount of the monthly contribution, which can be changed from time to time, is determined by the Fund, in its sole discretion. The Fund will make reasonable efforts to communicate any adjustment in the amount of the monthly self-contribution at least 30 days before any new rate goes into effect.

**Deduction from Annuity Check:** The monthly self-contribution will be deducted from an Annuitant's annuity check payable from the Fund.

**Personal Checks:** Personal checks will only be accepted under the following circumstances:

- If the amount of the self-contribution deduction exceeds the amount of an Annuitant's monthly annuity check, then an Annuitant's personal check may be used to make the monthly self-contribution.
- No personal checks will be accepted by the Fund until after the Retirement Board has approved an Annuitant's application for an Annuity.
- If the monthly self-contribution is payable by personal check, the first check must be received by the Fund no later than the first day of the month in which coverage begins.
- After the first payment, personal checks must be received by the Fund no later than the first day of the month for which coverage is to be provided. A 30-day grace period will be in effect, but if a payment is not received by the Fund within the 30-day grace period, coverage will terminate at the end of the 30-day grace period.

### 2. *Postponing, Suspending, and Reinstating Coverage*

- **Postponing Coverage:** If you or your spouse are employed and have other valid health plan coverage through an employer, you may elect to postpone your coverage under this Plan until you no longer have other health plan coverage. If you elect to postpone coverage for yourself, coverage for your Dependents will also be postponed. Dependents have no right to elect postponement. Reinstatement of coverage for Dependents after postponement will be effective on the date of your coverage reinstatement. You may be required to present documentation proving loss of other health coverage.
- **Suspending Coverage:** If you are covered under the Plan after meeting the eligibility requirements and the enrollment requirements in this Section, you may elect to suspend your coverage if you obtain other valid health plan coverage through an employer. You may suspend Plan coverage any time that you become employed and have other valid health coverage. If you elect

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to suspend coverage, your Dependents' coverage will also be suspended. You may be required to present document proving validity of other health coverage.

- **Permanent Termination of Coverage:** Coverage will be permanently terminated if you otherwise elect to terminate your coverage without providing evidence of "Eligible Coverage."
- **Reinstatement of Coverage:** You may reinstate suspended coverage under this Plan when you are no longer employed and do not have other health plan coverage through your employer. You must reenroll in the Plan by filing a completed enrollment form with the Fund no later than 30 days after your other health plan coverage ends. Coverage for Dependents will be reinstated along with your coverage.

## C. Termination of Coverage

### 1. *In General*

Termination of the plan in which you are enrolled automatically terminates your coverage.

Further, if you misrepresent or falsify information in connection with obtaining coverage or making any claim, then your coverage may terminate immediately or on such other date as determined by the Fund.

Once coverage terminates, other than through suspension or postponement described above, you will not be eligible to reenroll in the Plan.

No benefits are available for Covered Services rendered after the date of termination of benefits.

### 2. *Annuitant Coverage*

You may lose coverage under the Plan effective as of the end of the month upon the occurrence of any of the following events:

- A self-contribution is not made on a timely basis and full payment is not made within the applicable grace period, if any;
- Your Annuity terminates or you otherwise no longer meet the eligibility requirements set forth above;
- You enroll in a Medicare Part D Prescription Drug Plan; or
- You terminate your coverage.

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3. ***Dependent Coverage***

A Dependent may lose coverage under the Plan at the end of the month in which the following events occur:

- Your coverage, as Annuitant, under the Plan terminates;
- You die; or
- The Dependent no longer meets the definition of a Dependent herein.

4. ***Certificate of Creditable Coverage***

When you or any enrolled Dependent is no longer eligible for Plan benefits, you have a right to request a certificate of creditable coverage from your plan's ***Claim Administrator***. This certificate provides evidence of your prior health care coverage under the Plan. You may need to furnish this certificate if you become eligible under another group health plan that excludes coverage for pre-existing conditions. You may also need this certificate in order to buy an individual insurance policy that has a pre-existing condition exclusion or limitation. You also have the right to request one for any other reason. To request a certificate or to receive information regarding the certificate process or timing, please contact your plan's Claim Administrator (see ***Contact Information*** on page 2).

**D. Family Coverage – Dependents**

You may elect for "Family Coverage" as opposed to "Individual Coverage" when you enroll.

1. ***Eligibility***

If you are an Eligible Annuitant, your Dependent is eligible for Plan coverage if:

- He or she meets the requirements for "Eligible Dependent" status as set forth below.
- You supply the required information about your Dependent on the enrollment form and file such information with the Fund.
- You substantiate the Dependent's status by providing appropriate documentation to the Fund, such as a birth certificate, marriage certificate, adoption papers, records of your appointment as a foster parent or legal guardian, etc.

***Eligible Dependents*** of an Annuitant include his or her:

- Spouse
- Unmarried child from birth to age 26 who is dependent on the Annuitant for more than one-half of his or her support for the calendar year, including:
  - ◆ A natural child.

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- ◆ An adopted child or child placed for adoption.
  - ◆ A stepchild who lives with the Annuitant in a parent-child relationship at least 50% of the time.
  - ◆ Child for whom Annuitant has permanent legal guardianship.
  - Unmarried child age 26 and older who is mentally or physically handicapped and meets all of the following conditions if the child is:
    - ◆ Financially dependent upon the Annuitant for more than one-half of his or her support for the calendar year.
    - ◆ Eligible to be claimed as a Dependent for income tax purposes by the Annuitant.
    - ◆ Continuously disabled as determined by the Social Security Administration from a cause originating prior to age 26.
  - Any other child for whom the Plan has received a Qualified Medical Child Support Order with respect to a covered Annuitant.
  - A covered Annuitant's unmarried child over age 25 and under age 30 who:
    - ◆ Is a resident of Illinois.
    - ◆ Served as a member of the active or reserve component of any branch of the United States armed forces.
    - ◆ Has received an honorable release or discharge from the armed forces.
  - An unmarried child under 26 for whom the Annuitant has legal guardianship must:
    - ◆ Receive over one-half of his or her support from the Annuitant for the calendar year.
    - ◆ Have the same principal residence as the Annuitant for the calendar year.
    - ◆ Be a member of the Annuitant's household for the entire calendar year.
    - ◆ Not be a qualifying child of any other taxpayer under the terms of Internal Revenue Code Section 152 for the calendar year.
    - ◆ The guardianship relationship cannot violate local law.

***Military Service:*** A Dependent on active duty with the United States armed forces will still be eligible for coverage under the Plan, provided that he or she otherwise meets the eligibility requirements for Plan coverage.

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## **E. Making Enrollment/Coverage Changes**

### **1. *Adding & Removing Eligible Dependents – “Qualified Changes” -- Special Enrollment Options/Timing***

You may add new Dependents due to marriage, birth, adoption, obtaining legal guardianship, interim court order of adoption, placement of adoption, vesting temporary care, legal guardianship or if you become Medicare eligible. You must make the election within 31 days of the related event or coverage may be lost or delayed.

Before coverage can begin for a new Dependent that you acquire after your coverage has already begun, you must provide the Fund with documentation verifying that your Dependent meets the definition of an Eligible Dependent as described herein. The Fund must approve the verification documents before Dependent coverage can become effective.

If you provide verification to the Fund within the first 31 days after you acquire the Dependent, the new Dependent’s coverage will begin on the date the Dependent was acquired. However, if you provide verification to the Fund later than 31 days after the qualifying event, you will have to wait until the Group Health Benefit’s annual open enrollment period to do so.

### **2. *Annual Open Enrollment.***

You are entitled to make changes to your plan and coverage during the annual open enrollment election period.

If, during the year, you fail to notify the Fund of a qualifying event, you may make these changes during the open enrollment period.

All changes will become effective January 1 following the open enrollment period or such other date that the plan shall choose.

## **F. Survivors**

A “Survivor” is a Spouse or Dependent of a deceased Annuitant. Survivors will only be eligible for coverage as an “Annuitant” if they satisfy the annuitant eligibility and enrollment requirements.

## G. Benefit Eligibility/Enrollment Summary

Coverage is subject to satisfaction of all eligibility requirements, including completion of all enrollment materials and any eligibility requirements indicated by the provider.

Eligible Family Members	Important Eligibility Criteria / Coverage Notes	Enrollment Required Document(s)
Your Spouse		<b><u>CERTIFIED COPY OF MARRIAGE CERTIFICATE</u></b>
Your (and Your Spouse's) Unmarried Dependent Children -- Under <b>26</b> Years of Age.	<p><i><u>Includes:</u> In addition to Your (and Your Spouse's) Children, includes:</i></p> <ul style="list-style-type: none"> <li>• Children under your legal guardianship or who are in your custody under an interim court order pending adoption</li> <li>• Children for whom you are required by court order to provide health coverage.</li> </ul> <p><i><u>Excludes:</u></i></p> <ul style="list-style-type: none"> <li>• Foster children, grandchildren, etc. – unless legally adopted or under guardianship.</li> </ul> <p>Note: Coverage will end on the last day of the month in which the 26<sup>th</sup> birthday falls. (See below exception for "Disabled Children").</p>	<p><b><u>CERTIFIED COPY OF BIRTH CERTIFICATE</u></b></p> <p><b>OR</b></p> <p><b><u>FOR GUARDIANSHIP / CUSTODY:</u></b></p> <ul style="list-style-type: none"> <li>• <b><u>PENDING: CERTIFIED COPY OF PETITION FOR APPOINTMENT WITH CHILD'S BIRTH DATE LISTED.</u></b></li> <li>• <b><u>FINALIZED: CERTIFIED COPY OF LETTER OF OFFICE ISSUED BY COURT WITH CLERK'S SEAL AND BIRTH CERTIFICATE, IF BIRTH DATE IS ABSENT FROM LETTER OF OFFICE DOCUMENT OR PETITION FOR APPOINTMENT OF GUARDIANSHIP</u></b></li> </ul>
Disabled Children – No Age Limitation.	<ul style="list-style-type: none"> <li>• Children incapable of self-sustaining employment and dependent upon you or other care providers for support because of a disabling condition occurring prior to reaching the "limiting age" (i.e. 26) -- may be covered regardless of age.</li> </ul>	<b>ORIGINAL COPY OF LETTER FROM PHYSICIAN CERTIFYING DISABILITY ON PHYSICIAN'S LETTERHEAD SIGNED IN INK BY THE PHYSICIAN AND INCLUDING DATE DISABILITY OCCURRED.</b>

### 1. ***Benefit Recipient Responsibilities; Retroactive Reimbursement Policy***

Corrections to eligibility will be retroactively made to the appropriate effective date. To the extent that a retroactive correction results in a premium refund, a maximum of six months of premium may be refunded; provided that, no refund will be made if any claim was made after the effective date of such correction.

It is the Annuitant's, Dependent's, or Survivor's responsibility to advise the Plan immediately of changes in eligibility for coverage. *Example: A qualifying event that impacts your existing elections, such as marriage, adoption or death. See Page 12 for further details on qualifying events.*

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## SECTION III. COBRA CONTINUATION COVERAGE

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This Section of the Handbook, which serves as your General COBRA Notice, contains important information about the right of Eligible Dependents to elect COBRA continuation coverage, which is a temporary extension of coverage. ***COBRA continuation coverage is not available to Annuitants.***

This notice generally explains COBRA continuation coverage, when it may become available to your Eligible Dependents, and what you need to do to protect their right to receive it.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under Federal law, you should contact the Fund.

### A. COBRA Continuation Coverage in General

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this Section of the booklet. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Your Spouse and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. As noted above, COBRA coverage is not available to the Annuitant. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**Type of coverage:** If your Dependents choose COBRA continuation coverage, the Plan is required to provide health coverage that is basically the same coverage that your Dependents had before the event that triggered COBRA. Your Dependents will have the choice of electing COBRA continuation coverage for medical and prescription drug benefits.

**Cost of coverage:** Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Plan is permitted to charge the full cost of coverage for similarly situated Dependents plus an additional 2%.

<b>COBRA Qualifying Events</b>	
<b>A qualifying event is defined as any of the events shown below that result in a loss of coverage.</b>	
<b>Qualifying Events – Spouse or Dependent</b>	<b>Maximum Continuation Period</b>
Annuitant’s death, divorce or legal separation	36 months
Loss of Dependent Status	36 months
COBRA Qualified Beneficiaries who, after enrollment, obtain Medicare or coverage under another group health plan, which does not impose preexisting condition limitations or exclusions, are ineligible to continue COBRA coverage.	
The Plan reserves the right to terminate retroactively COBRA coverage if an individual is deemed ineligible. Premiums paid will not be refunded for coverage terminated retroactively due to ineligibility.	

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## B. Qualifying Events

**Spouse:** If you are the spouse of an Annuitant, you become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

- The Annuitant dies.
- The Annuitant becomes entitled to Medicare benefits (under Part A, Part B, or both) and elects to cancel the group health benefit.
- You become divorced or legally separated from the Annuitant.

If the annuity is simply terminated because the payment obligations have ceased, Spouses and other Dependents are not entitled to COBRA.

**Dependent Children:** Your Dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- The Annuitant dies.
- The Annuitant becomes entitled to Medicare benefits (under Part A, Part B, or both) and elects to cancel the group health benefit.
- The Annuitant and Dependent spouse become divorced or legally separated.
- The child stops being eligible for coverage under the Plan as a Dependent child.

### 1. ***When is COBRA Coverage Available?***

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund has been notified that a qualifying event has occurred.

### 2. ***You Must Give Notice of Some Qualifying Events***

For the other qualifying events (divorce or legal separation of the Annuitant and a spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Fund within 60 days after the qualifying event occurs. You must provide this notice to the Fund at the following address:

Cook County Pension Fund  
33 North Dearborn Street, 10th Floor  
Chicago, Illinois 60602.

### 3. ***How is COBRA Coverage Provided?***

Once the Fund receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Annuitants or Dependent Spouses may elect COBRA continuation coverage on behalf of their children.

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### C. Electing COBRA Continuation Coverage

A qualified beneficiary must elect coverage by the date specified on the COBRA election form. Failure to do so will result in loss of the right to elect COBRA continuation coverage under the Plan.

In determining whether to elect COBRA continuation coverage, a qualified beneficiary should consider the following consequences if he or she fails to continue group health coverage through COBRA:

- First, he or she may have pre-existing condition exclusions applied to him or her by other group health plans if he or she has more than a 63-day gap in health coverage. Election of COBRA continuation coverage may help a qualified beneficiary avoid such a gap.
- Second, he or she will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if he or she does not elect COBRA continuation coverage for the maximum time available.
- Finally, the qualified beneficiary should take into account that he or she has special enrollment rights under Federal law. He or she has the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after his or her Plan coverage ends because of the qualifying event listed above. The qualified beneficiary will also have the same special enrollment right at the end of COBRA continuation coverage if he or she elects coverage under this Plan for the maximum time available.

To elect COBRA continuation coverage, a qualified beneficiary must complete an election form provided by the Fund. The 60-day election period begins to run not earlier than the date the qualified beneficiary loses coverage due to a qualifying event and ends on the 60th day following the later of the date the qualified beneficiary would lose coverage, or the date the election notice is provided to the qualified beneficiary by the Fund.

If the qualified beneficiary does not submit a completed election form by the date shown on the form, he or she will lose his or her right to elect COBRA continuation coverage. If the qualified beneficiary rejects COBRA continuation coverage before the due date, he or she may change his or her mind as long as he or she furnishes a completed election form before the due date and coverage will begin on the date he or she furnishes the completed election form.

### D. When COBRA Continuation Coverage Ends

COBRA continuation coverage will be terminated before the end of the 36-month period of coverage if:

- Any required premium is not paid on time;

- 
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
  - A qualified beneficiary becomes entitled to Medicare benefits (eligible for and enrolled in coverage under Part A, Part B, or both); or
  - The Plan terminates.

COBRA continuation coverage may also be terminated for any reason that the Plan would terminate any other Eligible Person's coverage (such as misrepresenting or falsifying information to the Plan).

When COBRA continuation coverage ends, the Claim Administrator will provide each qualified beneficiary with a certificate of creditable coverage, which may reduce any pre-existing condition limitations under another health plan.

1. *If You Have Questions*

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to:

Cook County Pension Fund  
33 North Dearborn Street, 10th Floor  
Chicago, Illinois 60602  
Telephone: 312.603.1200

2. *Keep Your Plan Informed of Address Changes*

In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund.

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## SECTION IV. BENEFIT PLAN OVERVIEW

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### A. CHOOSING THE RIGHT PLAN FOR YOU

Choosing the right plan and optimizing the benefits offered in that plan is how you *care for you*. This approach reduces not only your chance for illness and disease but also, ultimately, your healthcare costs.

*Achieving this goal is largely determined by the following elements:*

1. Your choice of doctor and interactions with him or her.
2. The lifestyle choices you make to prevent health problems.
3. Properly managing any health problems that do occur.

*Factors you may wish to consider in choosing the right health plan:*

- What are the out of pocket costs to you?
- Does the plan provide access to the doctors and hospitals that everyone under your plan wants?
- Does the doctor have experience caring for your specific need?
- What special programs does the plan provide (nurse help lines, health education, wellness, disease management) and are they right for you?

*For your convenience, a brief comparison of the plans is attached to this handbook as Attachment A*

### B. DETAILED INFORMATION FOR EACH PLAN

*As stated in Section I. Introduction*, the Fund has contracted with insurance providers for each of the plans comprising the Group Health Benefit. The **Claim Administrator** (see Glossary) for each plan is responsible for providing each covered individual with a Certificate/Booklet explaining the benefit coverage, including details concerning covered services, claim filing procedures, etc. Contact the Claim Administrator for a copy of such Certificate/Booklet (see **Contact Information** on page 2). To the extent there is any conflict with this Handbook, the terms of the Certificate/Booklet will control.

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## C. PRESCRIPTION DRUG BENEFITS

If you choose to enroll in any of the plans included in the Group Health Benefit, you will automatically be covered by the prescription drug benefit administered by CVS/Caremark (See **Contact Information** on page 2). All drugs covered by the prescription drug benefit are FDA-approved and are deemed “medically necessary.”

If you have any questions concerning your prescription drug benefit, including whether or not a prescribed drug is covered and/or “medically necessary,” you should contact CVS/Caremark (*see Contact Information on page 2*) or refer to your prescription plan booklet.

### 1. **Generic vs. Brand Considerations**

There are certain instances where penalties may apply when generic drugs are available for a brand-name drug. If a generic is available but the pharmacy dispenses the brand due to your or your Physician’s request, you will pay the difference in cost between the brand drug and the generic drug, in addition to the brand co-payment. However, if your physician determines that there is a medical reason for you to take the brand name drug instead of an available generic drug, you may submit a co-pay exception request form, along with the attending physician’s statement for consideration to:

CVS Caremark, Inc.  
800 NW Chipman Road, Suite 5830  
Attention: Client Liaison Department  
Lees Summit, MO 64063

Fax: 1-816-347-3357

If approved, you will pay only the appropriate brand-name co-payment. Please contact CVS Caremark to obtain a copy of the co-pay exception request form (see **Contact Information** on page 2).

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## D. Important Notices

1. ***Benefits Not Constitutionally Guaranteed; Subject to Change and/or Termination.*** Section 9-239 of the Illinois Pension Code [40 ILCS 5/9-239] provides that the group coverage and benefits described in this Handbook are not and shall not be construed to be pension or retirement benefits for purposes of Section 5 of Article XIII of the Illinois Constitution of 1970. As stated above, the summarized benefits may be changed and/or terminated at any time.
2. ***Applicable Law Controls.*** The Group Health Benefit is meant to comply with applicable law and, in the event of any conflict, the applicable law will control.
3. ***Fraud; Misrepresentation.*** If any person misrepresents or falsifies information in connection with obtaining coverage or making any claim, their coverage lost immediately or on such other date as determined by the Fund.

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## SECTION V. COORDINATION OF BENEFITS SECTION

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Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. The Claim Administrator has the right to administer COB. Please see the Certificate/Booklet provided by your Claim Administrator for details.

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## SECTION VI. GLOSSARY

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The following definitions apply throughout the Plan, unless otherwise noted.

**Annuitant:** Shall have the meaning given such term in Section 9-239 of the Illinois Pension Code [40 ILCS 5/9-239].

**Claim Administrator:** The “Claim Administrator” for each plan comprising the Group Health Benefit is as follows [see *Contact Information* on page 3 for telephone number and web address]:

Group Plan/Benefit	Claim Administrator
BlueCross BlueShield PPO	BlueCross BlueShield
HMO Illinois – BlueCross BlueShield	BlueCross BlueShield
Unicare HMO	Unicare
BlueCross BlueShield Comprehensive Major Medical Plan	BlueCross BlueShield
Prescription Drug Benefit	CVS Caremark

**County Fund:** The County Employees’ and Officers’ Annuity & Benefit Fund of Cook County, Illinois established under Article 9 of the Illinois Pension Code [40 ILCS 5/9-101 et. seq.].

**County:** Cook County or the Forest Preserve District of Cook County, Illinois.

**Dependent:** See Section II.D. for listing of individuals who qualify as “Dependents”.

**Forest Preserve District Fund:** The Forest Preserve District Employees’ Annuity and Benefit Fund of Cook County established under Article 10 of the Illinois Pension Code [40 ILCS 5/10-101 et. seq.].

**Eligible Annuitant:** An Annuitant who satisfies the eligibility and enrollment requirements of the Plan.

**Eligible Dependent:** The Dependent of an Eligible Annuitant who satisfies the eligibility and enrollment requirements of the Plan.

**Eligible Person:** An Eligible Annuitant or Eligible Dependent who is enrolled in this Plan and who meets the eligibility requirements for this health coverage.

**Family Coverage:** Coverage for you and your Eligible Dependents under the Plan.

**Fund:** The County Fund and the District Fund, collectively.

**Individual Coverage:** Coverage under the Plan for yourself, the Annuitant, but not for your Eligible Dependents.

**Plan or Group Health Benefit:** The group health benefit currently offered by the Fund.

**Retirement Board:** The Retirement Board of the County Employees’ and Officers’ Annuity and Benefit Fund of Cook County and ex officio for the Forest Preserve District Employees’ Annuity and Benefit Fund of Cook County.

**Survivor:** The surviving spouse or child of a deceased Annuitant who becomes entitled to become an Annuitant, in accordance with the terms of the Eligibility Section, after the death of the original Annuitant.