

State of *Illinois*



Department of Central Management Services | Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 - May 31, 2013 | Effective July 1, 2013 - June 30, 2014



College Insurance Program

Benefit Choice is May 1 - May 31, 2013

**Benefit Choice Forms must be submitted to SURS
no later than Friday, May 31st! If you do not want to
change your coverage, you do not need to submit a form.**

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

Go to the 'Latest News' section of the Benefits website at
www.benefitschoice.il.gov
for group insurance updates throughout the plan year.

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Message to Benefit Recipients

The Benefit Choice Period will be **May 1 through May 31, 2013**, for all benefit recipients. **Elections will be effective July 1, 2013.** 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 CIP Benefit Choice form. Benefit recipients should complete the form **only** if changes are being made. If you are already enrolled in CIP and wish to make a change in coverage, please call SURS for a Benefit Choice form at (800) 275-7877 or visit the SURS website at www.surs.org or the Benefits website at www.benefitschoice.il.gov. The Benefit Choice form will only be sent upon request. If you are enrolling yourself or an eligible dependent for the first time during the Benefit Choice Period, please contact SURS for a CIP enrollment application. SURS will process the changes based upon the information indicated on the form.

During the Benefit Choice Period, benefit recipients may:

- Change health plans.
- Add dependent coverage if never previously enrolled (adding dependent coverage requires documentation).
- Drop dependent coverage.

If you keep your existing CIP group insurance coverage, it is **not** necessary to join a Medicare prescription drug plan this year. See page 5 for more information.

What You Should Know for Plan Year 2014

It is each member's responsibility to know their plan benefits in order to make an informed decision regarding coverage elections. Members should carefully review all the information in this booklet to be aware of the benefit changes for the upcoming plan year. **The Benefit Choice Period will be May 1 through May 31, 2013.** All elections will be effective July 1, 2013.

- **Federal Healthcare Reform** As a result of the Patient Protection and Affordable Care Act, additional preventive services for women, including well-woman visits, contraception and breastfeeding support, will be paid at 100% beginning July 1, 2013. For a full list of preventive services that are paid at 100%, see the Benefits website or contact your plan administrator.
- **HMO Illinois and BlueAdvantage HMO Medical Group Code** Members and/or dependents enrolling in HMO Illinois or BlueAdvantage HMO must enter a 3-digit medical group code on the Benefit Choice Election Form. Medical group codes can be found on the provider directory page of the plan administrator's website. Members may call HMO Illinois or BlueAdvantage HMO for assistance.
- **Dependent Eligibility Verification Audit** In an effort to control costs and ensure enrollment files are accurate, the State of Illinois will be conducting a dependent eligibility verification audit during FY2014.

Members are reminded that dependents can be dropped from coverage without proof of a qualifying change in status and without penalty during the Benefit Choice Period. If, during the dependent eligibility verification audit, a member is found to be covering an ineligible dependent, they may be subject to a financial penalty, including but not limited to, repayment of all premiums CIP made on behalf of the employee and/or the dependent, as well as expenses incurred by the Program.

Answers to common questions about the audit, as well as a list of documents required during the audit, will be available on the Benefits website once the audit begins.

- **Express Scripts/Medco Pharmacy Benefit Managers Merge** Express Scripts and Medco merged into one company in April 2012. The combined company is in the process of changing the name on all its communications to Express Scripts. Until the renaming process is complete, you will sometimes see the Medco name in pharmacy communications and on websites.

Please continue to refill your prescriptions as you normally would by using your current prescription drug ID card, refill order forms or the toll-free member services telephone number on your ID card. Medco is now a part of the Express Scripts family of pharmacies. Members with questions may call Express Scripts at (800) 899-2587.

- **Medicare Primary Retirees, Annuitants and Survivors** Effective January 1, 2014, Medicare primary retirees, annuitants and survivors (including those who have Medicare primary dependents on their health insurance coverage) may be required to enroll in a State-sponsored Medicare plan. Impacted members will receive a letter in the coming months outlining this change and their health plan choices.
- **Allowable Charges** For CCHP and OAP Tier III out-of-network services, the allowable charges methodology has changed. Contact your plan administrator for information.

Benefit Recipient Responsibilities

You must notify SURS if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses or partners of a dissolved civil union) must be reported to SURS immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment may not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You have or gain other coverage.** If you have group coverage provided by a plan other than CIP or if you or your dependents gain other coverage during the plan year.
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to the Medicare Coordination of Benefits Unit when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit at Central Management Services of your Medicare eligibility may result in substantial financial liabilities.** The Medicare Unit's address and phone number can be found on page 20.
- **You get married or enter into a civil union partnership; or your marriage or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **The employment status of your dependent changes.**

Contact SURS if you are uncertain whether or not a life-changing event needs to be reported.

Important Reminders

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 are 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 involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

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.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other benefit recipients.

Documentation Requirements: Documentation, including the SSN, is required when adding dependent coverage.



Coverage and Monthly Premiums

Benefit recipients who enroll in the College Insurance Program (CIP) receive health, prescription, behavioral health, dental and vision coverage. Dependent beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the benefit recipient.

As a benefit recipient enrolled in CIP, you are offered various health insurance coverage options:

◆ **College Choice Health Plan (CCHP)**

◆ **Managed Care Plans** (two types)

- Health Maintenance Organizations (HMOs)
- Open Access Plans (OAPs)

The health insurance options differ in the benefit levels they provide and the doctors and hospitals you can access. See the Benefits Comparison charts on pages 10-12 for information to help you determine which plan is right for you.

If you change health plans during the Benefit Choice Period, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. If you need to have services but have not yet received your ID cards, contact your health insurance carrier.

Remember, whatever health plan you elect during the Benefit Choice Period will remain in effect the entire plan year unless you experience a qualifying change in status that allows you to change plans.

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	\$103.79	\$259.46	\$362.23	\$108.00
	College Choice Health Plan	\$108.20	\$270.49	\$431.11	\$105.20
Dependent Beneficiary	Managed Care Plan	\$415.14	\$1,037.86	\$1,448.93	\$431.99
	College Choice Health Plan	\$432.78	\$1,081.96	\$1,724.44	\$420.81

* 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.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug Information for CIP Medicare Eligible Plan Participants

This Notice confirms that the College Insurance Program has determined that the prescription drug coverage it provides is creditable. This means that your existing prescription coverage is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan. Unless you qualify for low-income/extra-help assistance, you should not enroll in a Medicare Part D plan.

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your entire group coverage through 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 the loss of creditable coverage.

If you keep your existing group coverage, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll into a Medicare prescription drug plan; however, may need a personalized Notice of Creditable Coverage in order to enroll into a prescription plan without a financial penalty. Participants who need a personalized Notice may contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007.

Summary of Benefits and Coverage (SBC) and Uniform 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 new regulation is designed to help you better understand and evaluate your health insurance choices.

The new forms include a short, plain language Summary of Benefits and Coverage (SBC) and a uniform 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 SBC's are available on the Benefits website.

Notice of Privacy Practices

The Notice of Privacy Practices has been updated on the Benefits website effective April 1, 2013. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at www.benefitschoice.il.gov.

Changes that are effective April 1, 2013, include, but are not limited to, the following:

- References to the Department of Healthcare and Family Services (HFS) were replaced with Department of Central Management Services
- Contact information for the two self-insured open access plans (OAPs) were added
- The pharmacy benefit manager name was changed from Medco to Express Scripts
- Legal requirements were clarified
- Restrictions were updated
- 'Notice of changes' was updated

Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Health maintenance organizations (HMOs) have limitations including geographic availability and defined provider networks, whereas the two open access plans (OAPs) and the College Choice Health Plan (CCHP) have nationwide networks of providers available to their members.

All health plans require a determination of medical appropriateness prior to specialized services being rendered. HMO plans require the member to obtain a copy of the authorized referral prior to services being rendered. For CCHP and OAPs, it is the member's responsibility to make sure authorization of medical services has been obtained by the health plan provider to avoid penalties or nonpayment of services. Important note: OAPs are self-referral plans. It is the member's responsibility to ensure that the provider and/or facility from which they are receiving services are in Tier I or Tier II to avoid significant out-of-pocket costs. For more detailed information, refer to each health plan's summary plan document (SPD).

Allowable Charges For CCHP and OAP Tier III out-of-network services, the allowable charges methodology has changed. Contact your plan administrator for information.

College Choice Health Plan (CCHP)

CCHP is the medical plan that offers a comprehensive range of benefits. Under the CCHP, plan participants can choose any physician or hospital for medical services; however, plan participants receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a CCHP network provider. Plan participants can access plan benefit and participating CCHP network information, explanation of benefits (EOB) statements and other valuable health information online.

The CCHP has a nationwide network that consists of physicians, hospitals and ancillary providers. Notification to Cigna is required for certain medical services in order to avoid penalties. Contact Cigna at (800) 962-0051 for direction.

CCHP utilizes Magellan for behavioral health benefits and Express Scripts for prescription benefits.

Managed Care Plans

• Health Maintenance Organizations (HMOs)

Members who elect an HMO plan will need to select a primary care physician (PCP) from a network of participating providers. A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. The PCP will direct all healthcare services and will make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment will apply. There are no annual plan deductibles for medical services obtained through an HMO.

The minimum level of HMO coverage provided by all plans is described on the chart on page 10. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

If a member is enrolled in an HMO and their PCP leaves the HMO plan's network, the member has three options (must be elected within 30 days of the event):

- Choose another PCP within that plan;
- Change to a different managed care plan; or
- Enroll in the College Choice Health Plan.

Health Plan Descriptions (cont.)

Managed Care Plans

- **Open Access Plans (OAPs)**

Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. Members who elect an OAP 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. Members enrolled in an OAP can mix and match providers and tiers. Specific benefits are described on the chart on page 11 and may also be found in the summary plan document (SPD) on the OAP administrator's website.

- ◆ Tier I offers a managed care network which provide enhanced benefits and require copayments which mirror HMO copayments.
- ◆ Tier II offers another managed care network, in addition to the managed care network offered in Tier I, and also provides enhanced benefits. Tier II requires copayments, coinsurance and is subject to an annual plan year deductible.
- ◆ Tier III covers all providers which are not in the managed care network of Tiers I or II (i.e., out of network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involve higher out-of pocket costs. Tier III has a higher plan year deductible and has a higher coinsurance amount than Tier II services. In addition, certain services, such as preventive/wellness care, are not covered when obtained under Tier III. Furthermore, plan participants who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services (i.e., allowable charges), which could result in much higher out-of-pocket costs. When using out-of-network providers, it is recommended that the participant obtain a preauthorization of benefits to ensure that medical services/stays will meet medical necessity criteria and be eligible for benefit coverage.

Members who use providers in Tiers II and III will be responsible for the plan year deductible. These deductibles 'cross accumulate,' which means that amounts paid toward the deductible in one tier, will apply toward the deductible in the other tier.

Behavioral Health Services

College Choice Health Plan

Magellan Behavioral Health is the plan administrator for behavioral health services under the College Choice Health Plan (CCHP). Behavioral health services are included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the CCHP benefit schedule on page 12 for in-network and out-of-network providers. 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 10-11. 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 the College Choice Health Plan (CCHP) plan administrator 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 the CCHP plan administrator 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 page 20 and on the Benefits website.

To access website links to plan administrators, visit the Benefits website at www.benefitschoice.il.gov.

Health Plans by Illinois County

July 1, 2013 through June 30, 2014

Refer to the code key below for the health plan code for each plan by county.

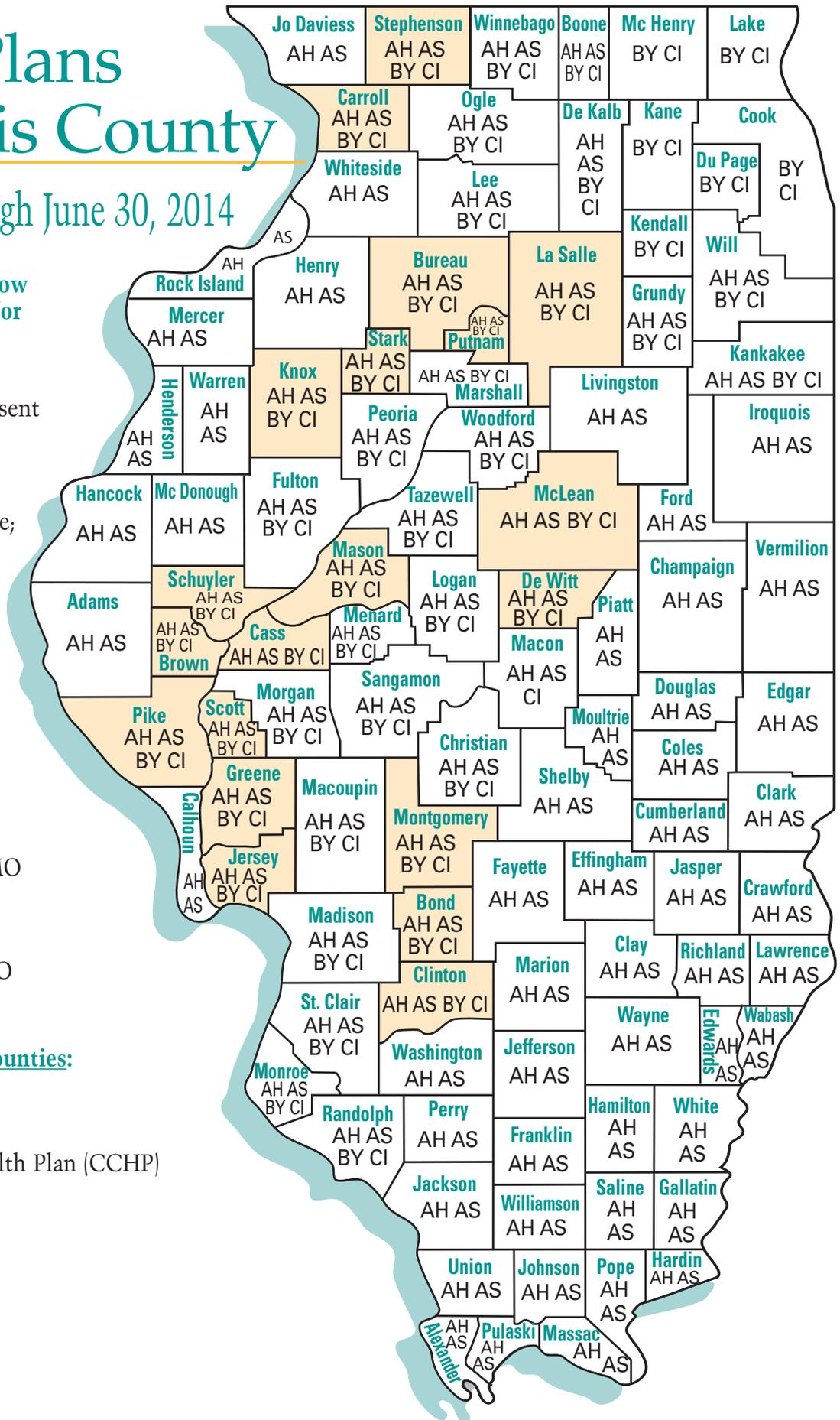
 Shaded areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.

The following plans are available in the counties indicated on the map:

- AH - Health Alliance HMO
- AS - Coventry HMO
- BY - HMO Illinois
- CI - BlueAdvantage HMO

The following plans are available in all Illinois counties:

- CH - Coventry OAP
- CF - HealthLink OAP
- D3 - College Choice Health Plan (CCHP)



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 \$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 member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan 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	\$0 \$0	\$700 \$1,400	\$1,700 \$3,600
Annual Plan Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*
Hospital Services			
Inpatient	100% after \$250 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) – Covered through the plan administrator, Express Scripts			
	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 plan benefits apply. Benefit limits are measured on a plan year. Plan copayments, deductibles and amounts over the plan's allowable charges do not count toward the out-of-pocket maximum.

The College Choice Health Plan (CCHP)

Plan Year Maximums and Deductibles

Plan Year Maximum	Unlimited								
Lifetime Maximum	Unlimited								
Plan Year Deductible	\$750 per participant								
Additional Deductibles*	<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								
* These are in addition to the plan year deductible.									

Hospital Services

CCHP Hospital Network	\$250 deductible per hospital admission. 80% after annual plan deductible.
Non-CCHP Hospitals	\$500 deductible per hospital admission. 60% of allowable charges after annual plan deductible.

Outpatient Services

Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Diagnostic Lab/X-ray	80% in-network, 60% of allowable charges 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 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, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services.
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Prescription Drugs (administered by Express Scripts)

Prescription Drugs (30-day supply)	Generic	\$12.50
	Preferred Brand	\$25.00
	Nonpreferred Brand	\$50.00
	Specialty	\$100.00

Behavioral Health Services

Magellan administers the CCHP Behavioral Health Services benefit. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611.

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100% of covered expenses up to the allowable charge for the remainder of the plan year. It is important to note that certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges ineligible for payment by the plan include prescription copayments, amounts over allowable charges for the plan, noncovered services, charges for services deemed to be not medically necessary and penalties for failing to precertify/provide notification.

The types of charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined below:

- **College Choice Health Plan:** The types of charges that apply toward the out-of-pocket maximum for CCHP include the annual plan year deductible, additional deductibles and coinsurance.
- **HMO Plans:** HMO plans apply copayments toward the out-of-pocket maximum.
- **OAP Plans:** OAP plans do not have an out-of-pocket maximum for Tier I; however, for Tiers II and III, only coinsurance is applied toward the out-of-pocket maximum. Also for Tiers II and III, the out-of-pocket maximum amount must be met for each tier and are cumulative between tiers. For example, once the 'individual' out-of-pocket maximum for Tier II has been met (i.e., \$700), coinsurance for Tier II providers is no longer required. However, if the same plan participant then goes to a Tier III provider (out-of-network), they will need to satisfy an additional \$1,000 to meet the out-of-pocket maximum for Tier III charges (i.e., \$1,700).

CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM					
PLAN	Out-of-Pocket Maximum Limits	Annual Plan Year Deductible	Additional Deductibles/Copayments	Coinsurance	Amounts over Allowable Charges* CCHP out-of-network providers and OAP Tier III providers)
CCHP	In-Network Individual \$1,500 Family \$3,000	X	X	X	Amounts over the plan's allowable charges are the member's responsibility and do not go toward the out-of-pocket maximum.
	Out-of-Network Individual \$4,500 Family \$9,000				
HMO	Individual \$3,000 Family \$6,000		X		
OAP Tier II	Individual \$700 Family \$1,400			X	
OAP Tier III	Individual \$1,700 Family \$3,600			X	

* **Allowable Charges:** Effective July 1, 2013, the methodology for determining **allowable charges** will be changing. Members who use out-of-network providers should contact their health plan administrator for information regarding out-of-network charges before obtaining services.

Plan Participants (Benefit Recipients 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 premium-free 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 (if the plan covers prescription drugs). 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 contribution, unless the participant qualifies for extra-help assistance as determined by the SSA.

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.

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 State of Illinois 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.

Civil union partner dependents who are eligible for premium-free Medicare Part A upon turning the age of 65 are required by the College Insurance Program to enroll in Medicare Part B. Once enrolled, Medicare will be the primary payer for the partner’s coverage regardless of the member’s current employment status.

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 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.

Prescription Benefit

Plan participants enrolled in any CIP health plan have prescription drug benefits included in the coverage. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's prescription benefit manager (PBM) for coordination of benefits (COB) information. 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.



Formulary Lists: All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's PBM. Formulary lists categorize drugs in four levels: generic, preferred brand, nonpreferred and specialty. Each category has a different copayment amount. Coverage for specific prescription drugs may vary depending upon the health plan. **Formulary lists are subject to change any time during the plan year.**

Certain health plans notify plan participants by mail when a prescribed medication they are currently taking is reclassified 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.

The maximum fill that CCHP plan participants can obtain at one fill at a retail pharmacy is 60 days worth of medication; however, plan participants can obtain a 90-day supply of medication through the mail order pharmacy. A 90-day supply through the mail order pharmacy will cost two copayments instead of three.

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.

Specialty Drug Category

A specialty drug is a medication that typically costs \$500 or more per dose or \$6,000 or more per year and has one or more of the following characteristics:

- Is a complex therapy for a complex disease;
- Is used for specialized patient training and coordination of care (services, supplies or devices) and is required prior to therapy initiation and/or during therapy;
- Has unique patient compliance and safety monitoring requirements;
- Has unique requirements for handling, shipping and storage; or
- Has a potential for significant waste.



Express Scripts: (800) 899-2587
Website: www.express-scripts.com

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 dependents 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; benefit recipient responsible for balance over \$90)	\$20 allowance
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

* 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 Plan

All benefit recipients and enrolled dependents have the same dental benefits available regardless of the health plan selected.

Dental Benefit

The College Choice Dental Plan (CCDP) is a dental plan that offers a comprehensive range of benefits 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.

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.

- **Delta Dental PPOSM Network** If you go to a PPO-level dentist you can maximize your dental benefits and minimize your out-of-pocket expenses because these providers accept a lower negotiated PPO fee (less any deductible). If the PPO fee is lower than the amount listed on the Schedule of Benefits, the PPO dentist cannot bill you for the difference.
- **Delta Dental PremierSM Network** If you go to a Premier-level dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier-level fee (less any deductible). If the allowed fee is lower than the amount listed on the Schedule of Benefits, the Premier dentist cannot bill you for 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 benefits as provided by the Schedule of Benefits. You will likely pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists will charge you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

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

It is strongly recommended that plan participants obtain a pretreatment estimate for any service over \$200, regardless of whether that service is to be received from an in-network or an out-of-network provider.

Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs. A pretreatment estimate is a review by Delta Dental of a dental provider's proposed treatment, including diagnostic, x-ray and laboratory reports, as well as the expected charges. This treatment plan is sent to Delta Dental for verification of eligible benefits. Obtaining a pretreatment estimate to verify coverage will help you make decisions regarding your dental services and help you avoid unanticipated out-of-pocket costs. Questions regarding a pretreatment estimate can be addressed by Delta Dental.

Plan participants can access CCDP network information, explanation of benefits (EOB) statements and other valuable information online by registering with Delta Dental of Illinois Member Connection.

* Orthodontics + all other covered services = Plan Year Maximum Benefit

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

Dental Plan (cont.)

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. Out-of-network dentists can elect to accept assignment from the plan or may require other payment terms. 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.

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 maximum 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 benefit recipient 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 based on the length of treatment (see 'Length of Orthodontia Treatment' chart below). This lifetime maximum applies to each plan participant regardless of the number of courses of treatment. **Note:** The annual plan year deductible must be satisfied each plan year that the plan participant is receiving orthodontia treatment unless it was previously satisfied for other dental services incurred during the plan year.

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

Prosthetic Limitations

(Prosthetics include full dentures, partial dentures and crowns)

- Prosthetics to replace missing teeth are covered only for teeth that are lost while the plan participant is covered by CCDP.
- 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.



Plan Administrators

Who to contact for information



Health Plan Administrators	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
College Choice Health Plan (Cigna)	(800) 962-0051	(800) 526-0844	www.cigna.com/stateofil
Coventry Health Care HMO	(800) 431-1211	(217) 366-5551	www.chcillinois.com
Coventry Health Care OAP	(800) 431-1211	(217) 366-5551	www.chcillinois.com
Health Alliance HMO	(800) 851-3379	(800) 526-0844	www.healthalliance.org/stateofillinois
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com/illinois_index.asp
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	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, Medicare COB Unit and Smoking Cessation Benefit	CMS Group Insurance Division 801 South 7th 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) 1901 Fox Drive P.O. Box 2710 Champaign, IL 61825-2710	(800) 275-7877 (800) 526-0844 (TDD/TTY)	www.surs.org



Plan Administrators

Who to contact 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) www.cigna.com/stateofil
CCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of \$400 applies	Cigna Group Number 2457490	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY)
Prescription Drug Plan Administrator CCHP (1399CD3) Coventry OAP (1399CCH) HealthLink OAP (1399CCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Express Scripts Group Number: 1399CD3, 1399CCH, 1399CCF Paper Claims: Express Scripts P.O. Box 14711 Lexington, KY 40512 Mail Order Prescriptions: Medco Health Solutions P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.express-scripts.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 plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits, program requirements and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.



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

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