

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.

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)

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.

If you keep your existing CIP group insurance coverage, it is **not** necessary to join a Medicare prescription drug plan this year. See the 'Federally Required Notices' page 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 flyer 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.

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

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%
Diagnostic Lab/X-ray	
Approved Durable Medical Equipment (DME) and Prosthetics	80% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
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.

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. The complete
Benefit Choice Options booklet and Benefit Choice form can be
found on the Benefits website at www.benefitchoice.il.gov

Go to the 'Latest News' section of the Benefits website at
www.benefitchoice.il.gov

for group insurance updates throughout the plan year.