



State of Illinois

Department of Central Management Services
Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 – June 20 2011

Teachers' Retirement Insurance Program

Effective July 1, 2011 - June 30, 2012

Plan Administrators

Who to contact for information

Plan Administrator	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
PersonalCare HMO	(800) 431-1211	(217) 366-5551	www.personalcare.org
PersonalCare OAP	(800) 431-1211	(217) 366-5551	www.personalcare.org

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Health Plans and the Medicare COB Unit	CMS Group Insurance Division 201 East Madison Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov
General Eligibility and Enrollment Information	Teachers' Retirement System (TRS) 2815 West Washington P.O. Box 19253 Springfield, IL 62794-9253	(800) 877-7896 (217) 753-0329 (TDD/TTY)	trs.illinois.gov

Plan administrator information continued on inside back cover.

Participant Responsibilities

It is each participant's responsibility to know plan benefits and make an informed decision regarding coverage elections. Notify the Teachers' Retirement System (TRS) immediately when any of the following occur:

- Change of address
- Qualifying change in status:
 - birth/adoption of a child;
 - marriage, divorce, legal separation, annulment;
 - death of spouse or dependent;
 - dependent(s) loss of eligibility;
 - a court order results in the gain or loss of a dependent;
 - a change in Public Aid recipient status;
 - dependent becomes covered by other group health coverage.
- Change in Medicare status
- Gain of, or change to, other group insurance coverage during the plan year. The participant must provide their coordination of benefits (COB) information to TRS as soon as possible.

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The Benefit Choice Period May 1 – June 20, 2011

The Benefit Choice Period will be **May 1 through June 20, 2011**, for all Benefit Recipients. Elections will be effective July 1, 2011. The Benefit Choice Period is the **only** time of the year a Benefit Recipient may change health plans, with the following two exceptions: the Benefit Recipient's permanent address changes affecting availability to the managed care plan or the primary care physician leaves the Benefit Recipient's managed care plan. Benefit Recipients or Dependent Beneficiaries who have never been enrolled in TRIP may enroll during the Benefit Choice Period.

All Benefit Choice changes should be made on the Benefit Choice Election form. Benefit Recipients should complete the form **only** if changes are being made. Dependent Beneficiaries must be enrolled in the same plan as the Benefit Recipient. If you are already enrolled in TRIP and wish to make a change in coverage, please call TRS for a new Benefit Choice form at (800) 877-7896 or visit the TRS website at trs.illinois.gov. The Benefit Choice form will only be sent to you upon request. If you are enrolling yourself or an eligible dependent for the first time during the Benefit Choice Period, please contact TRS for a TRIP enrollment application.

During the annual Benefit Choice Period, Benefit Recipients may:

- Change health plans
- Add dependent coverage if never previously enrolled

Additional Reminders About TRIP

To terminate coverage at any time, notify TRS in writing. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit Recipients and Dependent Beneficiaries who terminate from TRIP may re-enroll only upon turning age 65, upon becoming eligible for Medicare or if coverage is involuntarily terminated by a former plan.

Benefit Choice Changes for Plan Year 2012

(Enrollment Period May 1 – June 20, 2011)

The information below represents changes to the Teachers' Retirement Insurance Program benefit plans. Please carefully review all the information in this booklet to be aware of the benefit changes.

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

will be offered after September 28, 2011, will be provided as soon as it is available.

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

Other Plan Year 2012 Changes

- **Student and Student Leave of Absence** – Effective July 1, 2011, these dependent categories will no longer be available. Dependents enrolled in any of these categories will automatically be reclassified into the "Sponsored Adult Child" category by CMS during the month of August 2011. **Members do not need to take any action regarding this transition.**
- **Civil Union Partners** – Per Public Act 96-1513, the State of Illinois now requires employers to provide coverage for civil union partners and the dependents of civil union partners. June 1, 2011, will begin a 31-day qualifying change in status enrollment period for those members who have a valid Civil Union Partnership Certificate from another state. For members who obtain a Civil Union Partnership Certificate in Illinois, the 31-day qualifying change in status enrollment period will begin upon the issuance of the certificate. Enrollments will be processed in accordance with qualifying change in status rules.

Information and FAQs regarding coverage for civil union partners can be found on the Benefits website. **As the law permitting civil union partner coverage is not effective until June 1, 2011, coverage for civil union partners and their dependents CANNOT be requested during the Benefit Choice Period.**

- **Benefits Handbook** – A new Teachers' Retirement Insurance Program Benefits Handbook will be released on October 1, 2011. This handbook contains vital information for annuitants and survivors regarding the various benefits offered by the State. The handbook will be available on the Benefits website beginning October 1, 2011.

- **Federal Healthcare** – The following changes are a result of the Patient Protection and Affordable Care Act:

1. Annual and lifetime maximums have been eliminated.
2. Residency of a dependent child, except for a dependent child enrolled in the Adult Veteran category, is no longer relevant. Dependent children enrolled in the Adult Veteran category must reside in the State of Illinois to be eligible for coverage.
3. Marital status of a dependent child under the age of 26 is no longer relevant.
4. Preventive services are paid at 100%.

- **Prescription Drug Step Therapy (PDST)** – Beginning July 1, 2011, members enrolled in the Teachers' Choice Health Plan or one of the self-insured managed care plans will be subject to prescription drug step therapy (PDST). PDST is a program designed to encourage members to select lower cost drugs prior to moving to a higher cost therapeutic equivalent. See page 9 for more information.
- **TCHP Out-of-Pocket Maximum Change** – Effective July 1, 2011, all charges for out-of-network services for the Teachers' Choice Health Plan (TCHP) will be applied toward the 'Out-of-Network' out-of-pocket maximum and all charges for in-network services will be applied toward the 'In-Network' out-of-pocket maximum. Previously, all charges, except those incurred for out-of-network hospital services were applied toward the in-network, out-of-pocket maximum. See page 7 for more information about out-of-pocket maximums.

Coverage and Monthly Premiums

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

The health insurance plans available to TRIP members differ in the benefit levels they provide, the doctors and hospitals that can be accessed and the out-of-pocket costs. In general,

managed care plans, such as health maintenance organizations (HMOs) and the open access plans (OAPs), deliver healthcare through a system of network providers and have a lower monthly premium than the Teachers' Choice Health Plan (TCHP). The TCHP allows plan participants to access any provider nationwide; however, enhanced benefits are available when services are received from a TCHP network provider. The monthly premium is based on the type of coverage selected and the permanent residence on file with TRS.

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 enrolled in any managed care plan	\$59.29	\$184.13	\$250.87	\$72.77
Benefit Recipient enrolled in TCHP when a managed care plan is available in their county of residence	\$153.85	\$434.21	\$653.03	\$189.46
Benefit Recipient enrolled in TCHP when a managed care plan is not available in their county of residence	\$76.92	\$217.11	\$326.52	\$94.73
Dependent Beneficiary enrolled in any managed care plan	\$237.20	\$736.50	\$1,003.45	\$252.09**
Dependent Beneficiary enrolled in TCHP when a managed care plan is available in their county of residence	\$307.69	\$868.41	\$1,306.04	\$378.93
Dependent Beneficiary enrolled in TCHP when a managed care plan is not available in their county of residence	\$307.69	\$868.41	\$1,306.04	\$284.20**

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit. See inside front cover for contact information.

** Medicare Primary Dependent Beneficiaries enrolled in a managed care plan, or in TCHP when no managed care plan is available, receive a premium subsidy.

Managed Care Plans in Illinois Counties

TRIP Managed Care Health Plans For Plan Year 2012

- Managed Care Available
- Managed Care Partially Available

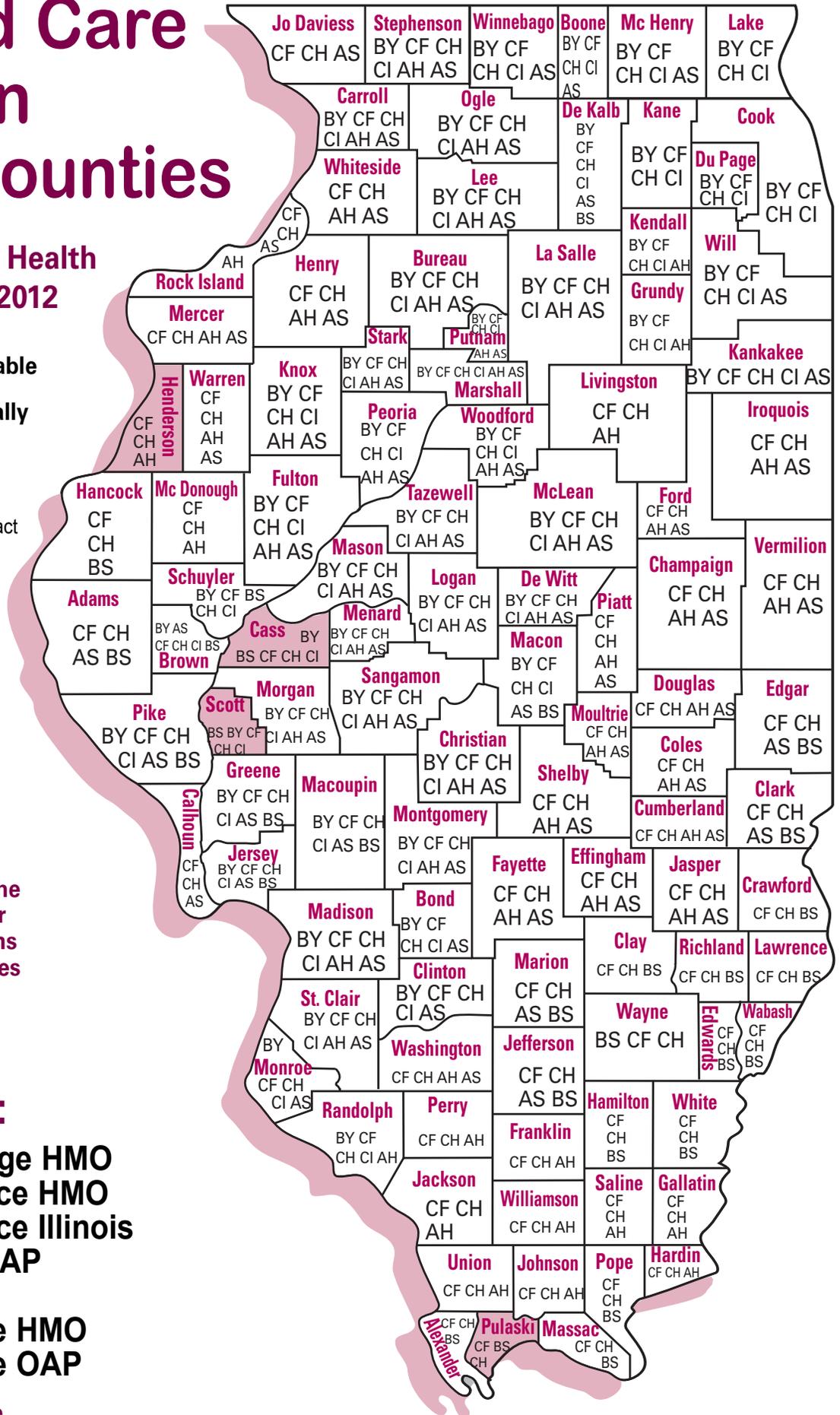
If a two-letter code appears in a shaded county, a managed care provider may be available. Contact the plan for information.

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

HMO & OAP Carrier Codes:

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

Note: TCHP available Statewide



HMO Benefits



Plan participants must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the plan participant pays only a copayment. No annual plan deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the plan participant's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design

Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Hospital Services

Inpatient hospitalization	100% after \$250 copayment per admission
Alcohol and substance abuse	100% after \$250 copayment per admission
Psychiatric admission	100% after \$250 copayment per admission
Outpatient surgery	100% after \$150 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after the lesser of \$200 copayment per visit, or 50% of U&C

Professional and Other Services

(Copayment not required for preventive services)

Physician Office visit	100% after \$20 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after \$20 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after \$20 copayment per visit
Prescription drugs (formulary is subject to change during plan year)	\$10 copayment for generic \$20 copayment for preferred brand \$40 copayment for nonpreferred brand
Durable Medical Equipment	80% of network charges
Home Health Care	100% after \$15 copayment per visit

Some HMOs may have benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The OAP provides three benefit levels broken into tier groups. Tier I and Tier II require the use of network providers and offer benefits with copayments and/or coinsurance. Tier III (out-of-network) requires higher out-of-pocket costs, but offers members flexibility in selecting healthcare providers. Tier II and Tier III require a deductible. It is important to remember the level of benefits is determined by the selection of healthcare providers. Plan participants enrolled in the OAP can mix and match providers. The benefits described below represent the minimum level of coverage available in the OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the plan participant's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan administrator for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee	\$0	\$700	\$1,700
Per Family	\$0	\$1,400	\$3,600
Annual Plan Deductible (must be satisfied for all services)	\$0	\$300 per enrollee*	\$400 per enrollee*

Hospital Services

Inpatient	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Inpatient Psychiatric	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after \$250 copayment per admission	80% of network charges after \$300 copayment per admission	60% of U&C after \$400 copayment per admission
Emergency Room	100% after \$200 copayment per visit	100% after \$200 copayment per visit	100% after \$200 copayment per visit
Outpatient Surgery	100% after \$150 copayment per visit	80% of network charges after \$150 copayment	60% of U&C after \$150 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of U&C

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

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

Other Services

Prescription Drugs – Covered through State of Illinois administered plan			
	Generic \$10	Preferred Brand \$20	Nonpreferred Brand \$40
Durable Medical Equipment	100%	80% of network charges	60% of U&C
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after \$15 copayment	80% of network charges	Covered under Tier I and Tier II only

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

The Teachers' Choice Health Plan (TCHP)

The Teachers' Choice Health Plan (TCHP), administered by CIGNA, is the medical plan that offers a comprehensive range of benefits. Under the TCHP, 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 TCHP network provider.

The TCHP has a nationwide network (Open Access Plan (OAP)) that consists of physicians, hospitals and ancillary providers. Notification to Intracorp, the TCHP notification administrator, is required for certain medical services in order to avoid penalties. Contact Intracorp at (800) 962-0051 for direction. **Note:** The TCHP is separate from the OAP health plans described on page 6.

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

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

Plan Year Maximums and Deductibles

Plan Year Maximum	Unlimited
Lifetime Maximum	Unlimited
Plan Year Deductible	\$500 TCHP Primary Participant (Non-Medicare) \$500 Medicare Primary Participant
Additional Deductibles*	Each emergency room visit \$400 TCHP hospital admission \$200 Non-TCHP hospital admission \$400 Transplant deductible \$200
* These are in addition to the plan year deductible.	

Out-of-Pocket Maximums

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

In-Network: \$1,200 per individual \$2,750 per family per plan year	Out-of-Network: \$4,400 per individual \$8,800 per family per plan year
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The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits, deductibles or copayments.
- Notification penalties.
- Ineligible charges (amounts over usual and customary (U & C), charges for noncovered services and charges for services deemed not to be medically necessary).
- The portion (\$50) of the Medicare Part A deductible the plan participant is responsible to pay.

TCHP - Plan Benefits

Hospital Services

TCHP Hospital Network	<ul style="list-style-type: none"> • \$200 deductible per hospital admission. • 80% after annual plan deductible.
Non-TCHP Hospitals	<ul style="list-style-type: none"> • \$400 deductible per hospital admission. • 60% of U&C 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 U&C out-of-network, after annual plan deductible.
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services

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

Transplant Services

Organ and Tissue Transplants	80% after \$200 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Intracorp. To assure coverage, the transplant candidate must contact Intracorp prior to beginning evaluation services.
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Behavioral Health Services

Magellan administers the TCHP Behavioral Health Services benefit. Authorization is required for all behavioral health services. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611.

Network providers are subject to change throughout the plan year. Always call the respective plan administrator to verify participation of a specific provider.

Prescription Drug Benefit

Plan participants enrolled in any TRIP health plan have prescription drug benefits included in the coverage. All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred brand. Each level has a different copayment amount. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment. This cost difference does not apply toward the annual prescription out-of-pocket maximum. Plan participants who have additional prescription drug coverage, including Medicare, should contact their plan's PBM for coordination of benefits (COB) information. TCHP has 20% coinsurance with minimum and maximum copayments. TCHP plan participants can receive a 90-day supply of maintenance medication through the Mail Order Program for two copayments and applicable coinsurance.

PRESCRIPTION DRUG COPAYS FOR ALL MANAGED CARE PLANS (30-DAY SUPPLY)		
Generic		\$10
Preferred (Formulary) Brand		\$20
Nonpreferred Brand		\$40
PRESCRIPTION DRUG COPAYS/COINSURANCE FOR TCHP (30-DAY SUPPLY)		
	Minimum	Maximum
Generic	\$7	\$50
Preferred (Formulary) Brand	\$14	\$100
Nonpreferred Brand	\$28	\$150
<ul style="list-style-type: none"> • Annual prescription drug out-of-pocket maximum of \$1,500 applies. • After meeting the \$1,500 out-of-pocket maximum, prescriptions are covered at 100%. • Out-of-network claims do not count toward this annual out-of-pocket maximum. • 20% coinsurance with minimum and maximum copayments. • The maximum supply at one fill is 60 days. • Prescription drug benefits are independent of other medical services and are not subject to the medical plan year deductible or the medical out-of-pocket maximums. 		

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

Prescription Drug Step Therapy

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

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

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

Plan Participants (Members and Dependents) Eligible for Medicare

What is Medicare?

Medicare is a federal health insurance program for the following:

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

Medicare has the following parts to help cover specific services:

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

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

To ensure that healthcare benefits are coordinated appropriately and the correct premium is charged, plan participants must notify TRS when they become eligible for Medicare and send TRS a copy of their Medicare identification card. Plan participants should contact the State of Illinois Medicare COB Unit for any questions via phone at (800) 442-1300 or (217) 782-7007.

Teachers' Retirement Insurance Program (TRIP) 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, **TRIP requires** that the plan participant 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 TRS. Plan participants who are ineligible for premium-free Medicare Part A, as determined by the SSA, are not required to enroll in Medicare.

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

Retirees, Survivors and Disabled Participants without Current Employment Status (and their applicable Dependents)

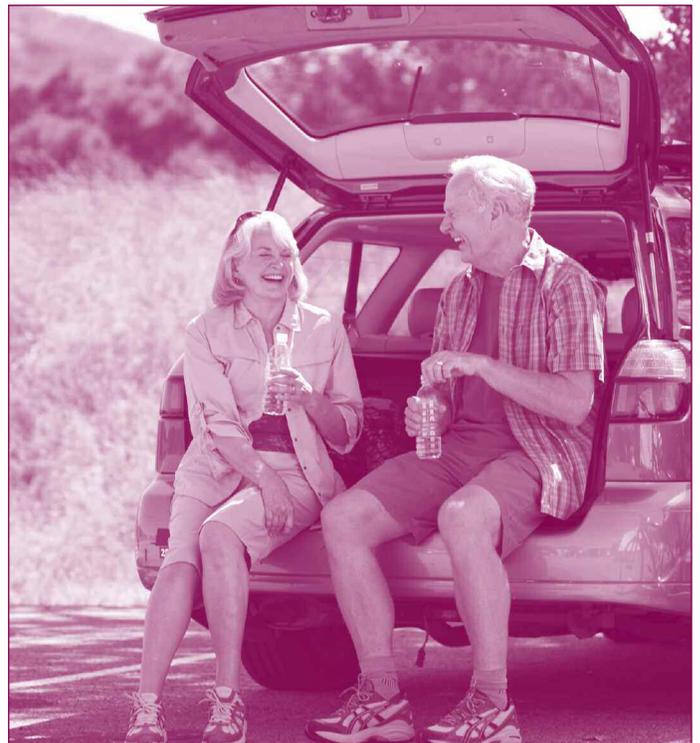
Plan participants (including dependents) who are retired, a survivor or a disability recipient without Current Employment Status (such as no longer working due to a disability) who are eligible for premium-free Medicare Part A must enroll in Medicare Part A, but may decline enrollment in Medicare Part B. However, even though TRIP does not require plan participants to enroll in Medicare Part B, **participants who receive the lower Medicare primary TRIP premium (due to having both Medicare Parts A and B) are required to maintain their enrollment in Medicare A and B.** Participants receiving the Medicare primary premium will be subject to the higher non-Medicare primary premium if disenrollment from Medicare Part B occurs. Furthermore, the participant will be charged the higher premium rate retroactively to the date Medicare Part B was terminated. **Plan participants who terminate Medicare Part B coverage must notify TRS immediately and provide the date the coverage terminated.**

For the TRIP premium rates, please refer to the monthly premium chart on page 3.

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

Plan participants at any age 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 the Medicare requirements and to ensure the proper calculation of the 30-month Coordination of Benefit Period.

Each plan participant who becomes eligible for Medicare is required to submit a copy of his/her Medicare card to his/her Group Insurance Representative (GIR) at the Teachers' Retirement System (TRS). You may contact TRS at (800) 877-7896.



Behavioral Health Services

Teachers' Choice Health Plan:

Behavioral health services are now included in an enrollee's annual plan deductible and annual out-of-pocket maximum. Behavioral health services are not subject to separate copayments, limits or other specific provisions. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the Teachers' Choice Health Plan (TCHP) benefit schedule on pages 7 and 8 for in-network and out-of-network providers. Magellan Behavioral Health is the plan administrator for behavioral health services under TCHP. 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 5 and 6. Please contact the managed care plan for specific benefit information.

Disease Management Programs and Wellness Offerings

Disease Management Programs:

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

Wellness Offerings:

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



Plan Administrators

Who to call for information

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Contact Information
Teachers' Choice Health Plan (TCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	CIGNA Group Number 2457490 CIGNA HealthCare P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
TCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of \$1,000 applies	Intracorp, Inc.	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com/soi.html
Prescription Drug Plan Administrator TCHP (1402TD3) PersonalCare OAP (1402TCH) HealthLink OAP (1402TCF) Health Alliance Illinois (1402TBS)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	Medco Group Number: 1402TD3, 1402TCH, 1402TCF, 1402TBS Paper Claims: Medco Health Solutions P.O. Box 14711 Lexington, KY 40512 Mail Order Prescriptions: Medco P.O. Box 30493 Tampa, FL 33630-3493	(800) 899-2587 (nationwide) (800) 759-1089 (TDD/TTY) www.medco.com
TCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for Behavioral Health Services	Magellan Behavioral Health Group Number 2457490 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the program is maintained for the exclusive benefit of the Teachers' Retirement Insurance Program (TRIP) Benefit Recipients. TRIP reserves the right to change any of the benefits and contributions described in this Benefit Choice Options booklet. This booklet is produced annually and is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options booklet, the Benefits Handbook and state or federal law, the law will control.



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