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

Teachers' Retirement Insurance Program

Benefit Choice is May 1 - May 31, 2013

Benefit Choice Forms must be submitted to TRS 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**. Benefit recipients or dependent beneficiaries who have never been enrolled in TRIP may enroll during the Benefit Choice Period. 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 their HMO plan or the primary care physician leaves the benefit recipient's HMO plan.

All Benefit Choice changes should be made on the TRS Benefit Choice 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 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 Benefit Choice Period, benefit recipients may:

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

If you keep your existing TRIP group insurance coverage, it is **not** necessary to join a Medicare prescription drug plan this year. See page 8 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 TRIP 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.
- **TCHP Coordination of Benefits Change for Medicare Primary Plan Participants** Effective July 1, 2013, TRIP will no longer pay 100% of the claim balance of medical claims after Medicare pays their portion for plan participants enrolled in TCHP. Medicare primary participants will be subject to the annual plan year deductible, as well as standard benefit coinsurance for in-network and out-of-network services after Medicare pays. Furthermore, plan exclusions for the TCHP Medicare primary plan participants will apply regardless of whether or not Medicare pays or denies the service. See pages 12 and 15 for more information and TCHP benefit levels.
- **Allowable Charges** For TCHP and OAP Tier III out-of-network services, the allowable charges methodology has changed. Contact your plan administrator for information.

Benefit Recipient Responsibilities

It is each benefit recipient'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.

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.

Terminating TRIP Coverage: 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.

Notification of Other Group Coverage: It is the benefit recipient's responsibility to notify TRS 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 TRS 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 Teachers' Retirement Insurance Program (TRIP) receive health, prescription and behavioral health coverage. Dependent beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the benefit recipient. The monthly premium is based on the type of coverage selected and the permanent residence on file with TRS.

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

✦ **Teachers' Choice Health Plan (TCHP)**

✦ **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	$65.36	$203.00	$276.58	$80.23
	TCHP	$169.61	$478.71	$719.96	$208.87
	TCHP when managed care is not available in your county	$84.80	$239.36	$359.99	$104.44
Dependent Beneficiary	Managed Care Plan	$261.51	$811.99	$1,106.30	$277.92**
	TCHP	$339.22	$957.42	$1,439.90	$417.77
	TCHP when managed care is not available in your county	$339.22	$957.42	$1,439.90	$313.33**

* 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.

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

Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Health maintenance organizations (HMOs) and the two open access plans (OAPs) have limitations including geographic availability and defined provider networks, whereas the Teachers' Choice Health Plan (TCHP) has a nationwide network 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 TCHP 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 TCHP and OAP Tier III out-of-network services, the allowable charges methodology has changed. Contact your plan administrator for information.

Teachers' Choice Health Plan (TCHP)

TCHP 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. Plan participants can access plan benefit and participating TCHP network information, explanation of benefits (EOB) statements and other valuable health information online.

The TCHP 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.

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

Managed Care Plans

- **Health Maintenance Organizations (HMOs)**

  Benefit recipients must 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 applies. No annual plan deductibles apply for medical services 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 benefit recipient is enrolled in an HMO and their PCP leaves the HMO plan's network, the benefit recipient 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 Teachers' 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.

  TRIP members living outside the State of Illinois may only enroll in an OAP if they reside in Arkansas or one of the following states contiguous with Illinois that offers an OAP: Indiana, Iowa, Kentucky, Wisconsin and Missouri. OAP access in these states may be limited. Contact TRS to find out if the plan is offered in your area.

  - ✦ 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

Teachers' Choice Health Plan

Magellan Behavioral Health is the plan administrator for behavioral health services under the Teachers' Choice Health Plan (TCHP). 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 TCHP 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.

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 and coinsurance, 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:

- **Teachers' Choice Health Plan:** The types of charges that apply toward the out-of-pocket maximum for TCHP 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* TCHP out-of-network providers and OAP Tier III providers)
TCHP	**In-Network** Individual $1,200 Family $2,750 **Out-of-Network** Individual $4,400 Family $8,800	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.**
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.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug Information for TRIP Medicare Eligible Plan Participants

This Notice confirms that the Teachers' Retirement 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 TRIP 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 TRIP 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 TRIP 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 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

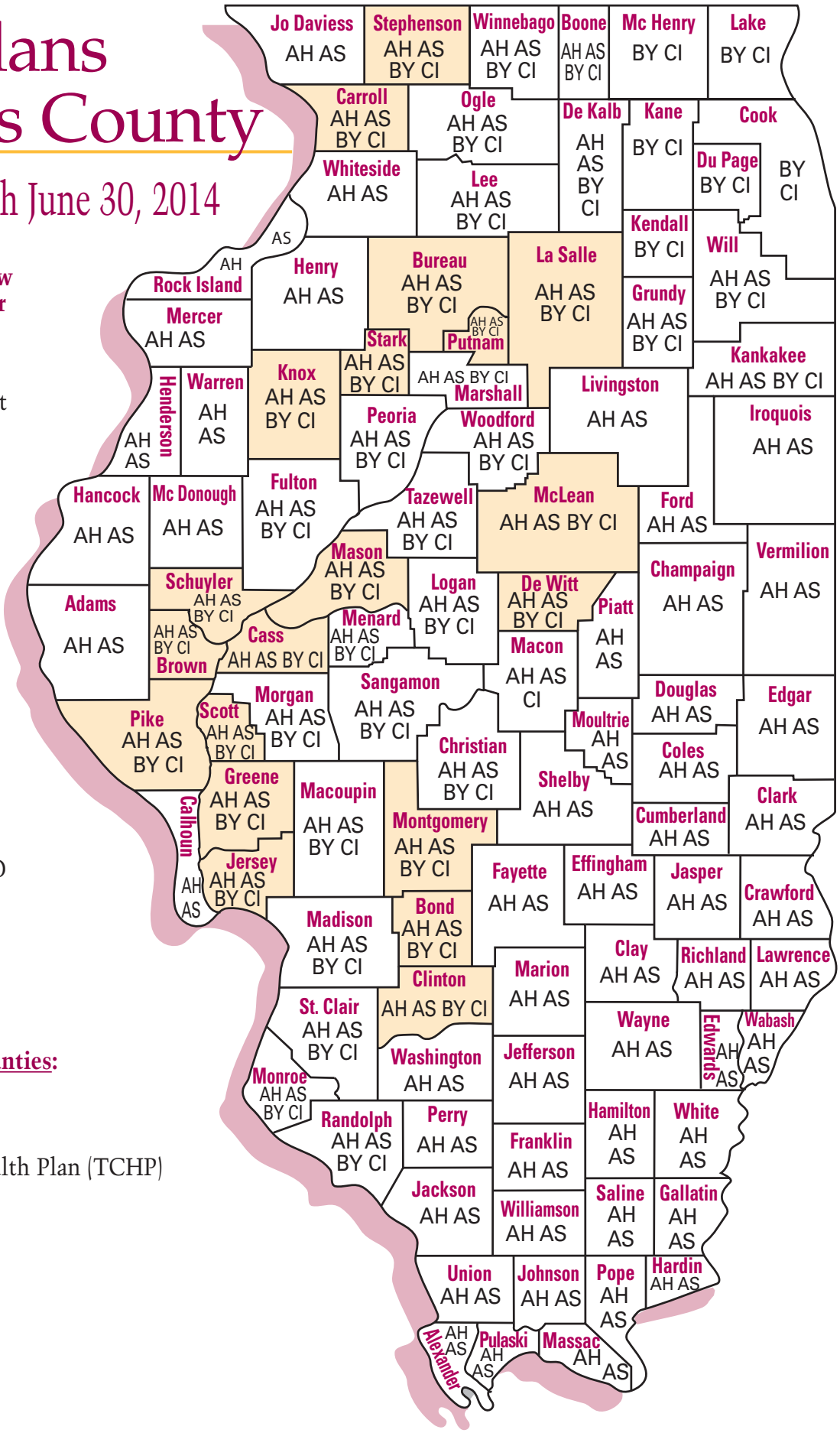
CI – BlueAdvantage HMO

The following plans are available <u>in all Illinois counties</u>:

CH – Coventry OAP

CF – HealthLink OAP

D3 – Teachers' Choice Health Plan (TCHP)



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 $200 copayment per visit
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 (30-day supply) (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%
Home Health Care	100% after $15 copayment per visit

Some HMOs may have benefit limitations based 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 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 $150 copayment per visit	80% of network charges after $150 copayment	60% of allowable charges after $150 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 $20 copayment	80% of network charges	60% of allowable charges
Specialist Office Visits	100% after $20 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 $20 copayment	80% of network charges	60% of allowable charges
Other Services			
Prescription Drugs (30-day supply) – Covered through the plan administrator, Express Scripts Generic $10 Preferred Brand $20 Nonpreferred Brand $40			
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 $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 the plan's allowable charges do not count toward the out-of-pocket maximum.

The Teachers' Choice Health Plan (TCHP)

Plan Year Maximums and Deductibles	
Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	$500 per participant
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit $400 TCHP hospital admission $200 Non-TCHP hospital admission $400 Transplant deductible $200

Hospital Services	
TCHP Hospital Network	$200 deductible per hospital admission. 80% after annual plan deductible.
Non-TCHP Hospitals	$400 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 TCHP Network	80% after the annual plan deductible.
Services not included in the TCHP 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 $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, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services.

Prescription Drugs (administered by Express Scripts)

Copayments (30-day supply)		Minimum	Maximum
TCHP applies 20% coinsurance to the retail cost of the drug not to exceed the maximum copayment or be less than the minimum copayment	Generic	Greater of 20% or $7	Lesser of 20% or $50
	Preferred Brand	Greater of 20% or $14	Lesser of 20% or $100
	Nonpreferred Brand	Greater of 20% or $28	Lesser of 20% or $150

Behavioral Health Services

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

Prescription Benefit

Plan participants enrolled in any TRIP 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 three levels: generic, preferred brand and nonpreferred. 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 TCHP 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.

TCHP Annual Prescription Out-of-Pocket Maximum

The Teachers' Choice Health Plan (TCHP) has an annual prescription drug out-of-pocket maximum of $1,500 per plan participant. Once this out-of-pocket maximum has been met, prescriptions obtained for the remainder of the plan year will be covered at 100%.

Amounts paid for coinsurance and copayments of prescriptions apply toward the prescription out-of-pocket maximum. Prescriptions obtained at an out-of-network pharmacy do not count toward the prescription annual out-of-pocket maximum, nor does the cost difference that a plan participant is charged when they obtain a brand drug (for any reason) when a generic is available.

Disease Management Programs and Wellness Offerings

Disease Management Programs

Disease Management Programs are utilized by the Teachers' Choice Health Plan (TCHP) 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 TCHP 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 16 and on the Benefits website.

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

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.
- **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.

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 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 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 termed.**

For the TRIP premium rates, please refer to the monthly premium chart on page 4.

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 the Teachers' Retirement System (TRS). You may contact TRS at (800) 877-7896.

TCHP Coordination of Benefits Change for Medicare Primary Plan Participants

Effective July 1, 2013, TRIP will no longer pay 100% of the claim balance of medical claims after Medicare pays its portion for a plan participant enrolled in TCHP. Medicare primary participants will be subject to standard benefit deductibles and coinsurance for in-network and out-of-network services (in accordance with page 12) after Medicare pays. Furthermore, plan exclusions for the TCHP will apply regardless if the claim has been paid or denied by Medicare.

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
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
Teachers' Choice Health Plan (Cigna)	(800) 962-0051	(800) 526-0844	www.cigna.com/stateofil

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Health Plans and Medicare COB Unit	**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	**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 Administrators

Who to contact 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 2457482 **Cigna HealthCare** P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) www.cigna.com/stateofil
TCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $1,000 applies	**Cigna** Group Number 2457482	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY)
Prescription Drug Plan Administrator TCHP (1402TD3) Coventry OAP (1402TCH) HealthLink OAP (1402TCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	**Express Scripts** Group Number: 1402TD3, 1402TCH, 1402TCF **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
TCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for behavioral health services	**Magellan Behavioral Health** Group Number 2457482 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.

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Printed by the authority of the State of Illinois
(CMS-BEN2002-02-1,000-04/13)
Printed on recycled paper