# Message to Benefit Recipients

The Benefit Choice Period will be held **May 1 through May 31, 2016**, for all benefit recipients **not** enrolled in the Medicare Advantage TRAIL Program. **Benefit Choice elections will be effective July 1, 2016.**

Benefit recipients or dependent beneficiaries who have never been enrolled in CIP may enroll during the Benefit Choice Period. 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.

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 the State Universities Retirement System (SURS) for a Benefit Choice form at (800) 275-7877. You may also access the form when you 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. 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).

**Attention Benefit Recipients with Medicare Parts A and B:** Benefit recipients who are enrolled in Medicare Parts A and B prior to October 1, 2016, will be required to elect coverage under the CIP Medicare Advantage TRAIL Program or elect to opt out of all CIP coverage. Refer to page 2 for more information regarding the Medicare Advantage TRAIL Program.

# 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.

| 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 | $109.33 | $273.32 | $370.95 | $111.19 |
| | College Choice Health Plan | $121.99 | $304.96 | $431.11 | $110.45 |
| Dependent Beneficiary | Managed Care Plan | $437.31 | $1,093.26 | $1,483.79 | $444.76 |
| | College Choice Health Plan | $487.94 | $1,219.86 | $1,724.44 | $441.79 |

* This rate applies to benefit recipients enrolled in Medicare Parts A and B, or benefit recipients enrolled in Medicare Part A only and whose Part B benefits are reduced. 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.

# What You Should Know for Plan Year 2017

**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, 2016**. All elections will be effective July 1, 2016.

- **Medicare Advantage 'TRAIL' Program:** CIP now provides coverage to eligible benefit recipients through the Medicare Advantage program. This program, referred to as the 'TRAIL' (Total Retiree Advantage Illinois), is available for benefit recipients enrolled in both Medicare Parts A and B.

  Each fall, benefit recipients who meet the criteria for enrollment in the Medicare Advantage 'TRAIL' Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. **These members will be required to choose a Medicare Advantage plan or opt out of all CIP coverage (opting out includes the termination of health, behavioral health, prescription drug, dental and vision coverage). Benefit recipients eligible for the TRAIL plans are no longer eligible for the plans offered during the Benefit Choice Period.**

  For more information regarding the Medicare Advantage 'TRAIL' Program, including eligibility criteria, go to **www.cms.illinois.gov/thetrail**.

- **Federal Healthcare Reform:** As a result of the Affordable Care Act (ACA), prescription copayments paid by members apply toward the annual out-of-pocket maximum. Once the maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year. The out-of-pocket maximum amount for each type of health plan varies and is outlined on page 14 of the Benefit Choice Options book.

## Basic Insurance Terms Explained

**What is an Insurance Premium?** Insurance **premiums** are the deductions taken out of your pension for your part of the insurance cost.

**What is a Copayment?** A **copayment** (or copay) is a fixed-dollar amount that you pay each time you have certain medical visits such as to an emergency room, or for certain procedures, such as physical therapy.

**What is a Deductible?** The **deductible** is the amount that you must pay toward your medical expenses before your plan will pay for any nonpreventive services.

**What is Coinsurance? Coinsurance** is your share of the cost for a covered service, calculated as a percentage of the allowed amount for the service. You pay coinsurance after you've met your deductible.

**What is an Out-of-Pocket (OOP) Maximum?** The **OOP** maximum is the most you will pay for eligible medical services and prescription drugs in a plan year. Once you meet your OOP maximum, the plan will pay 100% of eligible services. Coinsurance, copayments and deductibles all apply toward your out-of-pocket maximum.

# Federally Required Notices

## Notice of Creditable Coverage

Prescription Drug Information for CIP Medicare Eligible Benefit Recipients

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. Benefit recipients 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. Benefit recipients 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 regulation is designed to help you better understand and evaluate your health insurance choices.

The 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 July 1, 2015. 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**.

# Map of Health Plans by Illinois County

July 1, 2016 through June 30, 2017

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

BlueAdvantage HMO. . . . CI
Coventry HMO. . . . . AS
Coventry OAP . . . . . CH
Health Alliance HMO . . . AH
HealthLink OAP . . . . . CF
HMO Illinois. . . . . BY
College Choice Health Plan (CCHP). . . . . D3

AH, AS, BY, CF, CH, CI, D3

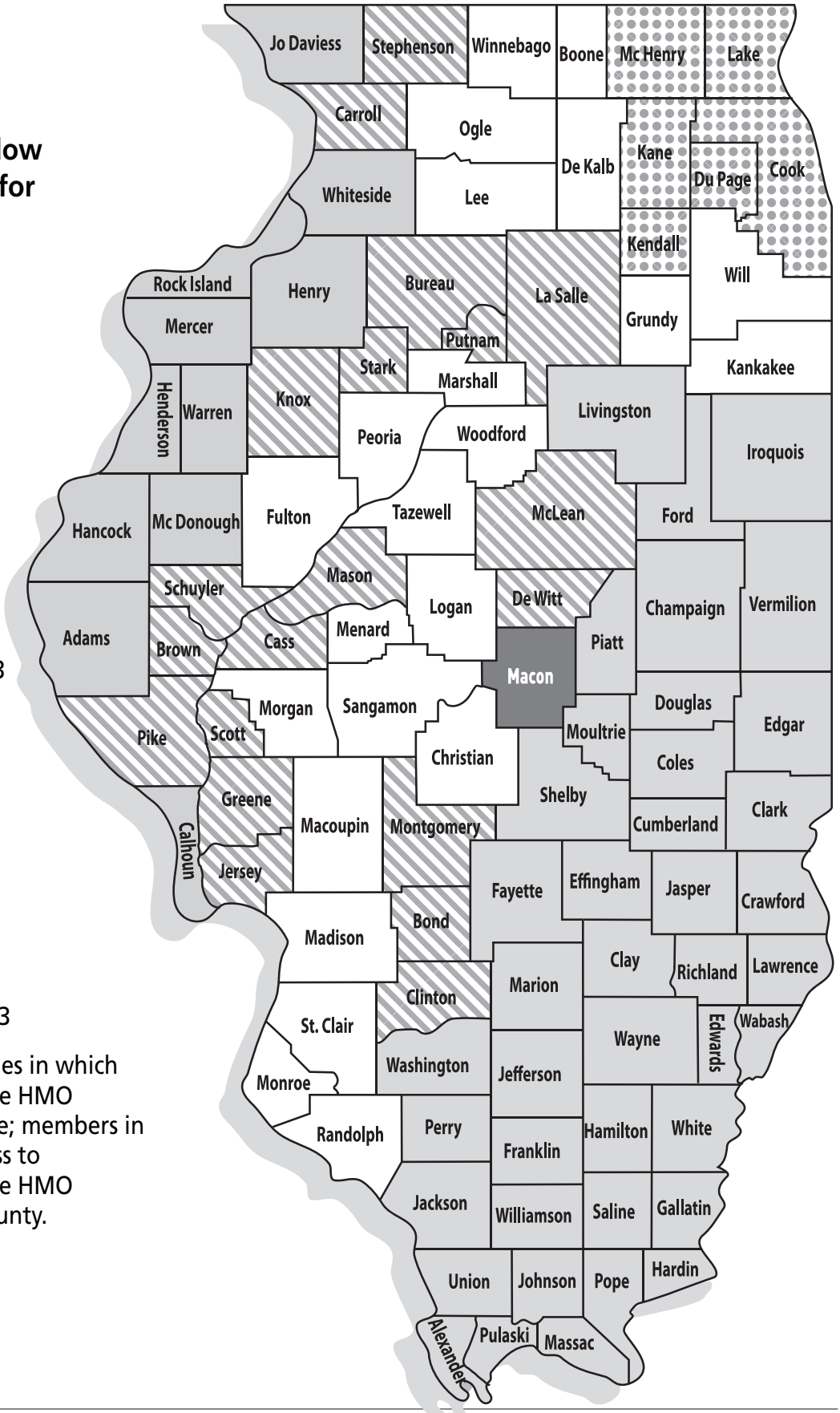
BY, CF, CH, CI, D3

AH, AS, CF, CH, D3

AH, AS, CF, CH, CI, D3

AH, AS, BY, CF, CH, CI, D3

Striped 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.



# HMO Benefits

Benefit recipients 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 benefit recipient 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 benefit recipient'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<br>(30-day supply)<br>(formulary is subject to change during plan year) | $12 copayment for generic<br>$24 copayment for preferred brand<br>$48 copayment for nonpreferred brand<br>$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<br>100% Benefit | Tier II<br>80% Benefit | Tier III (Out-of-Network)<br>60% Benefit |
|---|---|---|---|
| Plan Year Maximum Benefit | Unlimited | Unlimited | Unlimited |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited |
| Annual Out-of-Pocket Max<br>Per Individual Enrollee<br>Per Family | <br>$6,600 (includes eligible charges from Tier I and Tier II combined)<br>$13,200 (includes eligible charges from Tier I and Tier II combined) | | Not Applicable |
| 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**<br>**(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)<br>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 Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

# The College Choice Health Plan (CCHP)

| Plan Year Maximums and Deductibles | | |
|---|---|---|
| Plan Year Maximum<br>Lifetime Maximum | Unlimited<br>Unlimited | |
| Plan Year Deductible | $750 per benefit recipient | |
| Additional Deductibles*<br>* These are in addition to the plan year deductible. | Each emergency room visit<br>CCHP hospital admission<br>Non-CCHP hospital admission<br>Transplant deductible | $400<br>$250<br>$500<br>$250 |

| Out-of-Pocket Maximum Limits | | | |
|---|---|---|---|
| In-Network Individual | In-Network Family | Out-of-Network Individual | Out-of-Network Family |
| $1,500 | $3,000 | $4,500 | $9,000 |

| Hospital Services | |
|---|---|
| CCHP Hospital Network | $250 deductible per hospital admission.<br>80% after annual plan deductible. |
| Non-CCHP Hospitals | $500 deductible per hospital admission.<br>60% of allowable charges after annual plan deductible. |

| Outpatient Services | |
|---|---|
| Preventive Services, including immunizations | 100% in-network, 60% of allowable charges out-of-network, after annual plan deductible. |
| Diagnostic Lab/X-ray | 80% in-network, 60% of allowable charges out-of-network, after annual plan deductible. |
| Approved Durable Medical Equipment (DME) and Prosthetics | |
| Licensed Ambulatory Surgical Treatment Centers | |

| Professional and Other Services | |
|---|---|
| Services included in the CCHP Network | 80% after the annual plan deductible. |
| Services not included in the CCHP Network | 60% of allowable charges after the annual plan deductible. |
| Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year) | 80% in-network, 60% of allowable charges after the annual plan deductible. |

| Transplant Services | |
|---|---|
| Organ and Tissue Transplants | 80% after $250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services. |

| Prescription Drugs | | |
|---|---|---|
| Prescription Drugs<br>(30-day supply) | Generic<br>Preferred Brand<br>Nonpreferred Brand<br>Specialty | $12.50<br>$25.00<br>$50.00<br>$100.00 |


Printed by the Authority of the State of Illinois. 4/16 1.8M IOCI 16-342

# Benefit Choice is May 1 - May 31, 2016

## Benefit Choice Forms must be submitted to SURS no later than Tuesday, 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 their 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.benefitschoice.il.gov**

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