

Benefit Choice Period: May 1 - May 31, 2018

The Benefit Choice Period will be May 1 through May 31, 2018 for all eligible benefit recipients. Elections will be effective July 1, 2018.

Benefit recipients may make the following changes during the Benefit Choice Period:

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

For more information on your benefit options, go to MyBenefits.illinois.gov.

ONLINE ENROLLMENT PLATFORM

Making benefit elections is simple through the MyBenefits website. Follow these steps to register.

1. Log on to MyBenefits.illinois.gov.
2. In the top right corner of the home page, click **Login**.
3. Enter your login ID and password. If you are logging in for the first time, click Register in the bottom right corner of the login box and follow the prompts. You will need to provide your name as printed on the Benefit Choice Period materials mailed to your home.
4. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles or using the decision support tool.
5. After exploring your benefit options and determining which benefits you would like to elect, follow the prompts on the welcome page.

Contact MyBenefits Service Center (toll-free) 844-251-1777 or 844-251-1778 (TDD/TTY) with questions about navigating the MyBenefits website, or how to elect benefits. Representatives are available Monday – Friday, 8:00 AM – 6:00 PM CT.

Consider Going Paperless! Provide your email address on the MyBenefits website to receive quick responses and notifications through electronic communications.

Monthly Contributions

The College Insurance Program (CIP) shares the cost of health coverage with you. While CIP covers the majority of the cost, you must make monthly contributions based upon the health plan you select.

Type of Participant	Type of Plan	Not Medicare Primary		Medicare Primary*	
		Under Age 26	Age 26-64	Age 65 and Above	All Ages
Benefit Recipient	Managed Care Plan (OAP and HMO)	\$119.60	\$299.01	\$418.58	\$117.52
	College Choice Health Plan	\$134.16	\$335.39	\$409.19	\$106.30
Dependent Beneficiary	Managed Care Plan (OAP and HMO)	\$478.41	\$1,196.04	\$1,674.31	\$470.08
	College Choice Health Plan	\$536.63	\$1,341.56	\$1,636.77	\$425.19

This rate applies to benefit recipients enrolled in Medicare Part A only and whose Part B benefits are reduced. 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 is Changing

The only change to the College Insurance Program (CIP) for FY2019 is your monthly contributions.

Go to the MyBenefits website if you are uncertain whether or not a life-changing event needs to be reported.

What is Not Changing

The MyBenefits online enrollment platform, launched last year, will continue to be of service to all of our members. A simplified plan comparison and election process is provided through online enrollment at MyBenefits.illinois.gov or by calling the MyBenefits Service Center (toll-free) 844-251-1777.

Plan Administrators

Plan administrators will remain the same for all healthcare plans including health, dental, vision, behavioral health, and prescription drugs.

Health Plan Options

There will be no changes to your health plan options this Benefit Choice Period. **If you wish to keep your coverage, no action is needed. If you wish to change your plan or carrier, go online at MyBenefits.illinois.gov.**

DOCUMENTATION REQUIREMENTS

Documentation, including the SSN, is required when adding dependent coverage. Documentation must be submitted to the MyBenefits website or MyBenefits Service Center no later than June 11, 2018. Failure to provide adequate documentation by this deadline may result in dependents not being added to your plan. Note: Any documentation received after May 31, 2018, may result in a delay of ID cards.

Total Retiree Advantage Illinois (TRAIL)

Medicare Advantage Prescription Drug Program

The State of Illinois offers retirees, annuitants and survivors a healthcare program referred to as the TRAIL. This program provides eligible members and their covered dependents comprehensive medical and prescription drug coverage through State-sponsored Medicare Advantage Prescription Drug Plans. In order to be eligible for the TRAIL MAPD program, a member (and all covered dependents) must be enrolled in Medicare Parts A and B and be a resident of the United States (or a US territory). The Department of Central Management Services (CMS) will notify all eligible members by mail prior to the start of the TRAIL Open Enrollment Period this fall. The TRAIL Open Enrollment Period runs from the middle of October through the middle of November each year. All elections made during the TRAIL Open Enrollment Period will be effective January 1st. **All newly eligible members must enroll** into a State-sponsored TRAIL plan or opt out of State insurance coverage during the fall open enrollment period. Members already enrolled in a TRAIL Medicare Advantage Prescription Drug Plan are not required to make changes.

For more information regarding the Medicare Advantage 'TRAIL' Program, go to MyBenefits.illinois.gov or contact the State of Illinois Medicare COB Unit, PO Box 19208, Springfield, Illinois 62794-9208, Fax: 217-557-3973.



State of Illinois
Medicare COB Unit
PO Box 19208
Springfield, IL
62794-9208
Fax: 217-557-3973

Terminating CIP Coverage

To terminate coverage at any time, contact the MyBenefits Service Center by calling (toll-free) 844-251-1777. 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 CIP may re-enroll only upon turning age 65, upon becoming eligible for Medicare or if coverage is involuntarily terminated by a former plan.

College Insurance Program Medicare Requirements

Each benefit recipient must contact the Social Security Administration (SSA) and apply for Medicare benefits upon turning age 65. If the SSA determines that a benefit recipient is eligible for Medicare Part A at a premium-free rate, CIP requires that the benefit recipient enroll in Medicare Parts A and B. Once enrolled, the benefit recipient is required to send a front side copy of the Medicare identification card to the State of Illinois Medicare COB Unit.

If the SSA determines that a benefit recipient 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 benefit recipient must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty. Benefit recipients who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA, are not required to enroll into Medicare.

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 administrator 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 per visit
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after \$200 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after \$30 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after \$30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after \$30 copayment per visit
Prescription drugs (30-day supply) (formulary is subject to change during plan year)	\$12 copayment for generic \$24 copayment for preferred brand \$48 copayment for nonpreferred brand \$96 copayment for specialty
Durable Medical Equipment	80%
Home Health Care	100% after \$30 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). It is the benefit recipient'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	\$6,600 (includes eligible charges from Tier I and Tier II combined) \$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 (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)			
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.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your annual out-of-pocket maximum; this varies by plan and geographic region.

College Choice Health Plan (CCHP) Benefits - Aetna

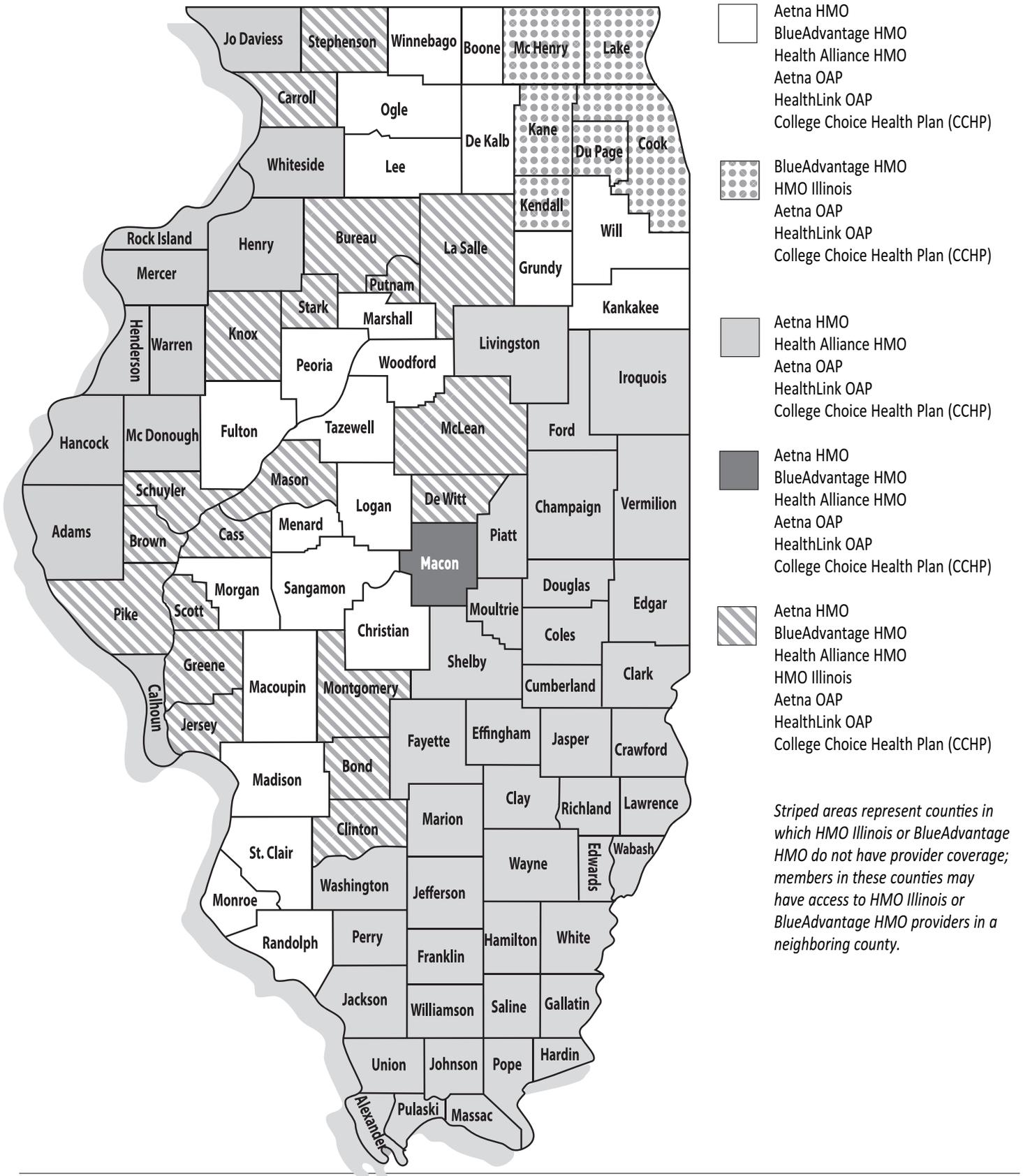
Plan Year Maximums and Deductibles			
Plan Year Maximum	Unlimited		
Lifetime Maximum	Unlimited		
Plan Year Deductible	\$750 per benefit recipient		
Additional Deductibles*	Each emergency room visit	\$400	
	CCHP hospital admission	\$250	
	Non-CCHP hospital admission	\$500	
	Transplant deductible	\$250	
Out-of-Pocket Maximum Limits			
In-Network Individual \$1,500	In-Network Family \$3,000	Out-of-Network Individual \$4,500	Out-of-Network Family \$9,000
Hospital Services			
CCHP Hospital Network	\$250 deductible per hospital admission. 80% after the annual plan deductible.		
Non- CCHP Hospitals	\$500 deductible per hospital admission. 60% of allowable charges after the annual plan deductible.		
Outpatient Services			
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after the annual plan deductible.		
Diagnostic Lab/X-ray	80% in-network, 60% of allowable charges out-of-network, after the 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, Aetna. To assure coverage, the transplant candidate must contact Aetna prior to beginning evaluation services.		
Prescription Drugs			
Copayments (30-day supply)	Generic	\$12.50	
	Preferred Brand	\$25.00	
	Nonpreferred Brand	\$50.00	
	Specialty	\$100.00	

* These are in addition to the plan year deductible.

** Using out-of-network services may significantly increase your out-of-pocket expense. Amounts over the plan's allowable charges do not count toward your annual out-of-pocket maximum; this varies by plan and geographic region.

What is Available in Your Area in FY19

Review the following map and charts to compare plans. Then, review your monthly contribution and out-of-pocket maximums to determine which plan is best for you.



Federally Required Notices

Notice of Creditable Coverage

Prescription Drug information for CIP Medicare-eligible Plan Participants

This Notice confirms that the College Insurance Program (CIP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through CIP 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.

Because your existing coverage is 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 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 your CIP coverage ends.

If you keep your existing group coverage through CIP, it is not necessary to join a Medicare prescription drug plan this year. Plan participants who decide to enroll in a Medicare prescription drug plan may need to provide a copy of the Notice of Creditable Coverage to enroll in the Medicare prescription plan without a financial penalty. Participants may obtain a Benefits Confirmation Statement as a Notice of Creditable Coverage by contacting the MyBenefits Service Center (toll-free) 844-251-1777, or 844-251-1778 (TDD/TTY).

Summary of Benefits and Coverage (SBC) and 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 summary 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 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 SBCs, along with the glossary, are available on MyBenefits.illinois.gov.

Notice of Privacy Practices

The Notice of Privacy Practices will be updated on the MyBenefits website, effective July 1, 2018. 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 by the 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 MyBenefits.illinois.gov.



STATE OF ILLINOIS
Department of Central
Management Services
Bureau of Benefits

MARK YOUR CALENDAR: MAY 1-31, 2018

Benefit Choice Period

College Insurance Program

Discover Your Options

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STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

