

choice

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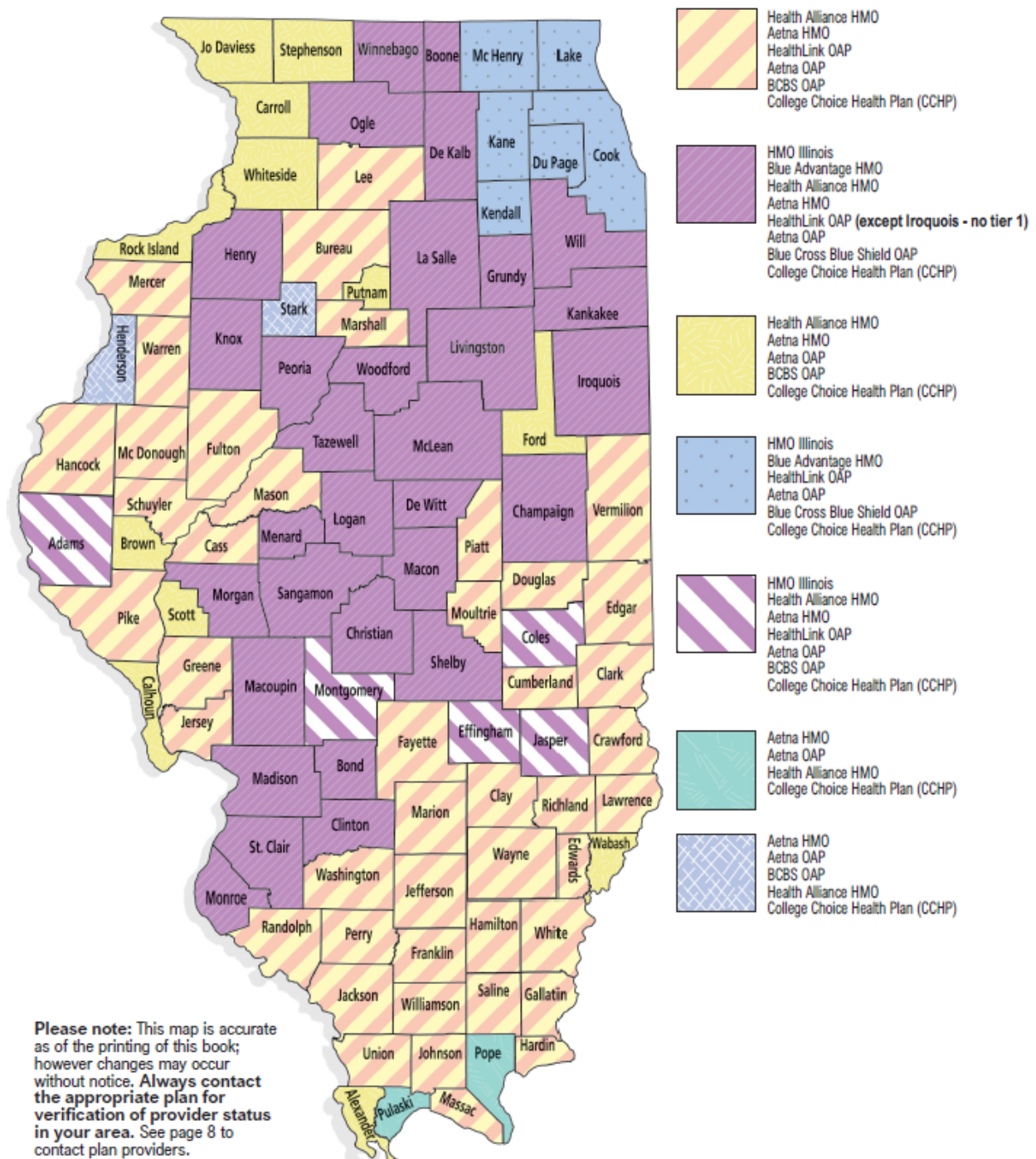
College Insurance Program

Open Enrollment Period is May 1, 2024 - May 31, 2024. Effective July 1, 2024

Plan Administrators available by County has changed.

New elections are required if your current health plan is no longer available in your residential county.

The map, in the printed version of the booklet, has since been updated; please use the online version.



Please note: This map is accurate as of the printing of this book; however changes may occur without notice. **Always contact the appropriate plan for verification of provider status in your area.** See page 8 to contact plan providers.

Health Plan Administrators

- Aetna HMO
- BlueAdvantage HMO
- BCBS HMO Illinois
- Health Alliance HMO

HMO



- Aetna OAP
- Blue Cross Blue Shield OAP
- HealthLink OAP

OAP



- College Choice Health Plan (CCHP) - Aetna PPO

PPO



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 Older	All Ages
Benefit Recipient	Managed Care Plan (OAP and HMO)	\$153.97	\$384.93	\$575.04	\$129.41
	College Choice Health Plan (CCHP)	\$192.86	\$482.16	\$727.62	\$164.25
Dependent Beneficiary	Managed Care Plan (OAP and HMO)	\$615.89	\$1,539.73	\$2,300.17	\$517.66
	College Choice Health Plan (CCHP)	\$771.45	\$1,928.63	\$2,910.49	\$657.02

* 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 (see page 8).

Monthly Contributions for Health, Dental and Vision.

Co-payments

- **HMO**
 - Plan year Out of Pocket Max:
 - \$3,000 Individual
 - \$6,000 Family
 - In-Network
 - Preventive Care 100%
 - Physician Office Visit, Specialist & Home Health Care Visit \$30
 - ER Services \$200
 - Inpatient Hospitalizations \$250
 - Outpatient Surgery \$200
 - Out-of-Network
 - Nothing is covered except ER Services \$200

Coinsurance & Deductibles

- **OAP**
 - Plan year Out of Pocket Max Tier I & II:
 - \$6,600 Individual
 - \$13,200 Family
 - Tier I
 - See HMO In-Network
 - Tier II \$300 Plan Year Deductible/Enrollee
 - Preventive Care 100%
 - Physician & Specialist 80%
 - ER Services \$200/visit
 - Inpatient Hospitalizations 80% after \$300 copay
 - Outpatient Surgery 80% after \$200 copay
 - No Out of Pocket Max
 - Tier III \$400 Plan Year Deductible/Enrollee
 - Preventive Care not covered
 - Physician & Specialist 60%
 - ER Services \$200
 - Inpatient Hospitalizations 60% after \$400 copay
 - Outpatient Surgery 60% after \$200 copay

Coinsurance & Deductibles

- **PPO-CCHP**
 - Plan Year Deductibles
 - \$750 per enrollee
 - In-Network – Deductible Applies
 - Preventive Care 100%
 - Physician & Specialist visits 80%
 - ER Services \$400
 - Inpatient Hospitalizations 80% after \$250
 - Outpatient Surgery 80%
 - Plan year Out of Pocket Max:
 - \$1,500 Individual
 - \$3,000 Family
 - Out-of-Network – Deductible Applies
 - Preventive Care 60%
 - Physician & Specialist 60%
 - ER Services \$400
 - Inpatient Hospitalizations 60% after \$500
 - Outpatient Surgery 60%
 - Plan year Out of Pocket Max:
 - \$4,500 Individual
 - \$9,000 Family

■ HMO

Prescription Drugs					
Plan Year Pharmacy Deductible – \$175 per enrollee		Preventive Prescription Drugs – \$0			
	Reduced Tier I *	Tier I	Tier II	Tier III	Specialty Tier
Copayments (30-day supply)	\$4	\$12	\$24	\$48	\$96
Copayments (90-day supply)	\$10	\$30	\$60	\$120	-

* Applies to specific medications as defined by the plan.
Some HMOs may have benefit limitations based on a calendar year.

Prescription Drugs Coverage

877-232-8128 or caremark.com

■ OAP



Prescription Drugs				
Preventive Prescription Drugs – \$0				
	Tier I	Tier II	Tier III	Specialty Tier
Copayments (30-day supply)	\$12	\$24	\$48	\$96
Copayments (90-day supply)	\$24	\$48	\$96	-
Maintenance Choice (90-day supply)***	\$12	\$24	\$48	-

- * A plan year 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 plan year out-of-pocket maximum; this varies by plan and geographic region.
- *** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.

■ PPO-CCHP

Prescription Drugs				
Preventive Prescription Drugs – \$0				
	Tier I	Tier II	Tier III	Specialty Tier
Copayments (30-day supply)	\$12.50	\$25.00	\$50.00	\$100.00
Copayments (90-day supply)	\$25.00	\$50.00	\$100.00	\$200.00
Maintenance Choice (90-day supply)**	\$12.50	\$25.00	\$50.00	-

- * 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 plan year out-of-pocket maximum; this varies by plan and geographic region.
- ** Medications received at CVS Caremark® Pharmacy or through CVS Caremark® Mail Service Pharmacy.

DIABETIC CARE SERVICE	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
<i>For Type 1 or Type 2 Diabetes with Diabetic Retinopathy</i>		
Medical Follow-Up Eye Examination	\$0 copay	Up to \$77
Extended Ophthalmoscopy (initial and subsequent)	\$0 copay	Up to \$15
Fundus Photography Examination	\$0 copay	Up to \$50
Gonioscopy	\$0 copay	Up to \$15
Scanning Laser	\$0 copay	Up to \$33

*Benefit frequency: All Diabetic Care Services are covered once every 6 months**



Service	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	\$10 copayment	\$20 allowance	Once every 24 months
Standard Frames	\$10 copayment (up to \$90 retail frame cost; member responsible for balance over \$90)	\$20 allowance	Once every 24 months
Vision Lenses* (single, bifocal and trifocal)	\$10 copayment	\$20 allowance for single vision lenses \$30 allowance for bifocal and trifocal lenses	Once every 24 months
Contact Lenses (All contact lenses are in lieu of vision lenses)	\$20 copayment for medically necessary \$50 copayment for elective contact lenses \$70 allowance for all other lenses not mentioned above	\$70 allowance	Once every 24 months

* Vision Lenses: Member pays all optional lens enhancement charges. In-network providers may offer additional discounts on lens enhancements and multiple pair purchase.

** Out-of-network claims must be filed within one year from the date of service.

- Vision coverage is still included with the Health Plan enrollment.
- EyeMed now offers additional coverage for Progressive Lenses, Premiums Anti-Reflective Coating and coverage for Photochromic and Polarized lenses.
- There are also new Diabetic Care Services.
- 866-723-0512 or eyemedvisioncare.com/stil

Deductible and Plan Year Maximum

Plan year deductible for preventive services	N/A
Plan year deductible for all other covered services	\$100
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
In-network plan year maximum benefit	\$2,000

It is strongly recommended that plan members obtain a pretreatment estimate through Delta Dental for any service more than \$200. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs.



- Dental coverage is still included with the Health Plan enrollment.
- Delta Dental of Illinois has a new enhanced coverage for individuals who have specific health conditions that can be positively affected by additional oral health care.
- 800-323-1743 or soi.deltadentalil.com



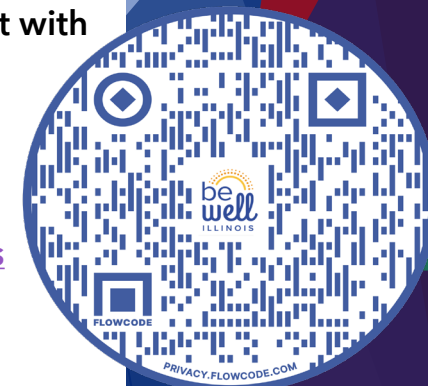
The State of Illinois' ongoing comprehensive approach to wellness.

Be Well Illinois is designed to not only focus on supporting your physical health but also your mental, financial, and social wellbeing. As a wellness plan member, you can use this site to access health plan information and educational resources including wellness webinars, monthly health awareness causes, financial wellness, healthy eating, and exercise.

While the decision to make healthy lifestyle changes is your choice and not a job requirement, the hope is that by creating an environment where these choices are supported by the work culture makes it easier and supports your success.

Engaging with Be Well Illinois is easy, connect with us in one of the following ways.

- Visit us at www.Illinois.gov/BeWell
- Follow us on Facebook at <https://www.facebook.com/BeWellIllinois>
- Or email us at BeWell@illinois.gov



Plan Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment Customer Service	MyBenefits Service Center (MBSC) 134 N. LaSalle Street, Suite 2200, Chicago, IL 60602	844-251-1777 844-251-1778 (TDD/TTY)	mybenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285657) Aetna OAP (Group Number 285653) College Choice Health Plan (CCHP) - Aetna PPO (Group Number 285662) Address for all Aetna Plans: PO Box 981106, El Paso, TX 79998-1106	855-339-9731 800-628-3323 (TDD/TTY) Fax: 859-455-8650 attn: Claims	aetnastateofillinois.com
	BlueAdvantage HMO (Group Number B06803) HMO Illinois (Group Number H06803)	800-868-9520 866-876-2194 (TDD/TTY)	bcbsil.com/stateofillinois
	Blue Cross Blue Shield OAP (Group Number 268988) Address for all Blue Cross Plans: PO Box 805107, Chicago, IL 60680-4112	855-810-6537	
	Health Alliance Medical Plans HMO (Group Number 1000042) 3310 Fields South Drive, Champaign, IL 61822	800-851-3379 800-526-0844 (TDD/TTY)	healthalliance.org/ stateofillinois
	HealthLink OAP (Group Number 160003) PO Box 419104, St. Louis, MO 63141-9104	877-379-5802 877-232-8388 (TDD/TTY)	healthlink.com/soi/ learn-more
Prescription Drug Plan	CVS Caremark® (for CCHP or OAP Plans) Group Numbers: (CCHP 1399CD3) (Aetna OAP 1399CCH) (BCBSIL OAP 1399CCJ) (HealthLink OAP 1399CCF) Paper Claims: CVS Caremark® PO Box 52136, Phoenix, AZ 85072-2136 Mail Order Rx: CVS Caremark® PO Box 94467, Palatine, IL 60094-4467	877-232-8128 800-231-4403 (TDD/TTY)	caremark.com
Vision Plan	EyeMed Out-of-Network Claims PO Box 8504, Mason, OH 45040-7111	866-723-0512 TTY users, call 711	eyemedvisioncare.com/stil
Dental Plan	Delta Dental of Illinois (Group Number 20242) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
State Universities Retirement System	1901 Fox Drive Champaign, IL 61820	800-275-7877 800-526-0844 (TDD/TTY) 217-378-8800 (dial direct) 217-378-9800 (fax)	surs.org

Illinois Department of Central Management Services

CMS

Login

[Make a Payment \(E-Pay\).](#)

[How to Register \(Video\).](#)

TO BROWSE THE PORTAL AS A GUEST, PLEASE TELL US IN WHICH STATE OF ILLINOIS GROUP INSURANCE PROGRAM YOU BELONG:

STATE EMPLOYEES GROUP
INSURANCE PROGRAM (SEGIP)

COLLEGE INSURANCE PROGRAM
(CIP)

LOCAL GOVERNMENT HEALTH
PLAN (LGHP)

TEACHERS' RETIREMENT
INSURANCE PROGRAM (TRIP)

Mybenefits.Illinois.gov
844-251-1777

Select



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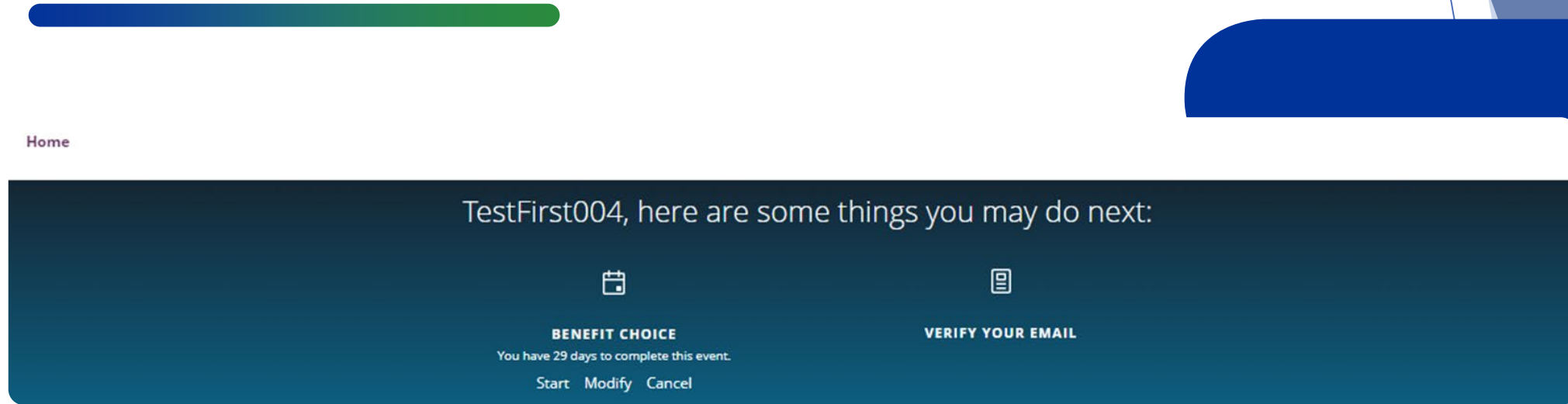


Select

Select



Personalized Home Page



- Displays events that need to be processed
- Update email address
- Self-Service tools
- Plan information

Terms and Conditions

I hereby declare that I have completed my enrollment or modified my coverage, my contribution rate, or other information because of: Benefit Choice. I understand that the modifications made during this session are effective 7/1/2024, subject to the approval of any required documentation and statement of health. I understand that I cannot change or stop my elections during the plan year unless I experience a qualifying change in status as permitted by the Program.

I certify that the information and documentation I have provided is true and complete. I understand that falsifying or misrepresenting any information or documentation, or failing to provide requested information or documentation, in order to obtain or continue coverage under the Program will be considered a fraudulent act which may result in the forfeiture of insurance coverage and that I may also be subject to a financial penalty, including but not limited to repayment of all premiums and claims paid by the State on behalf of myself or any of my dependents and all expenses incurred by the Program arising out of the coverage.

[Read full terms and conditions](#)



I agree to the Terms and Conditions

[Go back and make changes](#)

[Complete Enrollment](#)

- ▶ You must agree to the Terms and Conditions at the end of the enrollment flow, by checking the box at the bottom of the screen and click the green 'Complete Enrollment' button to finalize your elections.

Enrollment Confirmed

Event type: Benefit Choice | July 1, 2024

[View my Enrollment Summary](#)

To do

Documents below are required to be filled and returned to MyBenefits. If you decide to download or upload them later, they will be available on the home page through the self-service tools.



 [Birth Certificate/Official Adoption Decree](#)

Submit by: June 10, 2024

Next

- ▶ A green check mark will display once elections have been successfully submitted.
- ▶ If documentation is required, you will see a message indicating what is required and when it must be submitted by.

Thank you for your participation!

