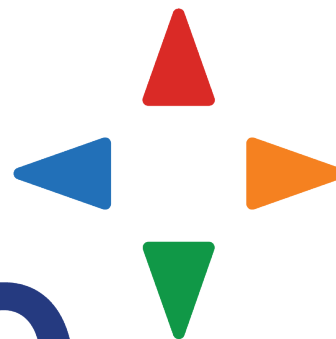




STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

FY 2023

benefit choice



Teachers' Retirement Insurance Program

Benefit Choice Period • May 1 - May 31, 2022

Effective July 1, 2022



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Benefit Choice Period

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ONLINE ENROLLMENT PLATFORM

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

1. Go to MyBenefits.illinois.gov.
2. In the top right corner of the home page, click **Login**.
3. 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. Enter your login ID and password. After logging in and landing on the welcome page, explore your benefit options by clicking on the benefit tiles.
5. After exploring your benefit options and determining which benefits you would like to elect, click on the Benefit Choice Event, located on the Welcome page.

Need Help?

AVA, the interactive digital assistant, is available online at MyBenefits.illinois.gov

Or

Contact [MyBenefits Service Center](https://MyBenefits.illinois.gov) (toll-free)
844-251-1777, or 844-251-1778 (TDD/TTY) with inquiries.

Representatives are available

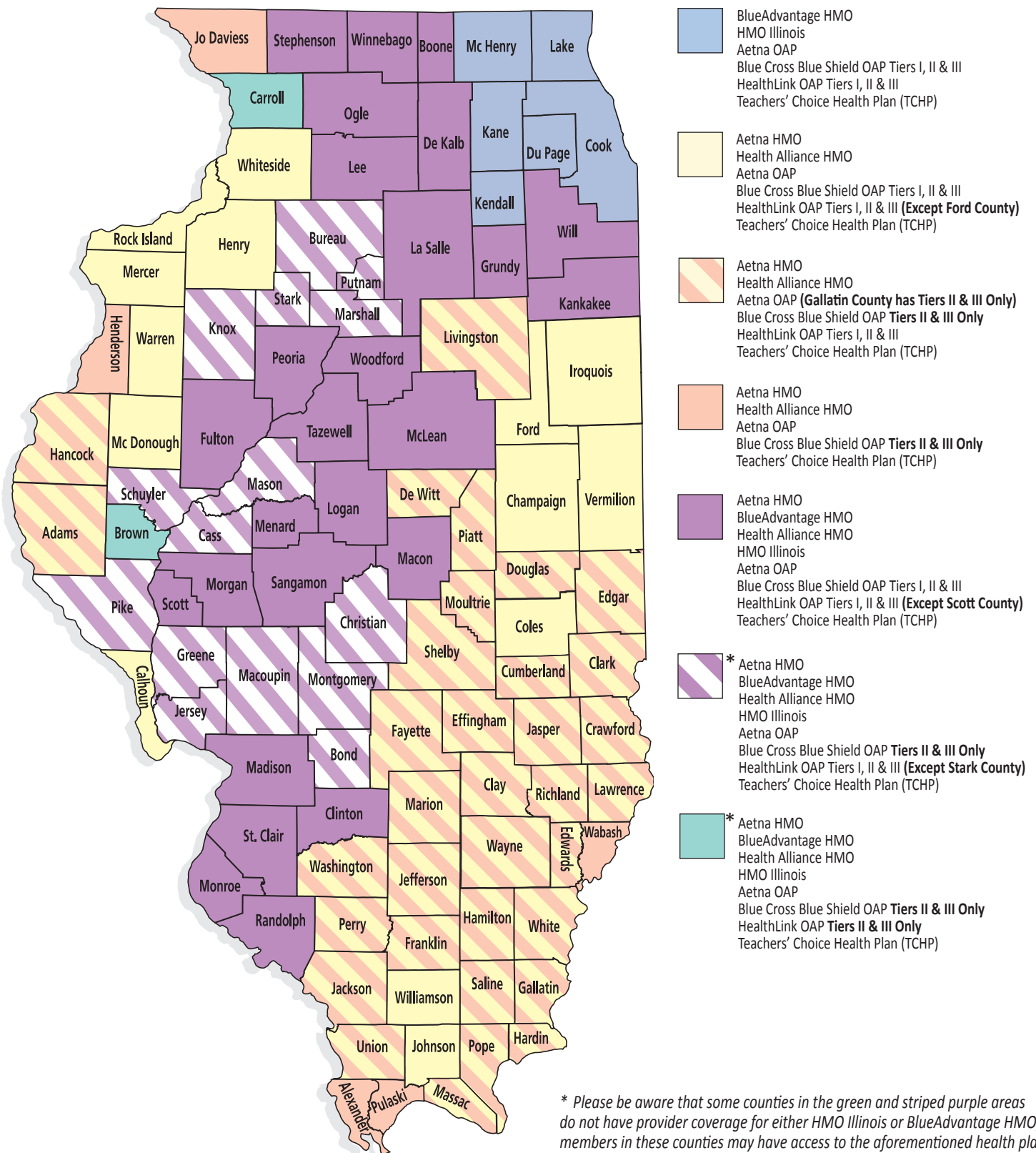
Monday – Friday, 8:00 AM - 6:00 PM CT.

WHAT YOU NEED TO DO

1. Go to MyBenefits.illinois.gov to review your benefit options.
2. Choose the benefits you'd like to elect at MyBenefits.illinois.gov between May 1-May 31, 2022.
3. Consider going paperless. Provide, or update your email address at MyBenefits.illinois.gov to receive quick responses and notifications through electronic communications.
4. Take advantage of your new benefits which will become effective July 1, 2022.

What is Available in Your Area in FY23

Review the following map and charts to identify plans available in your county. Then, review your monthly contribution and plan benefits to determine which plan is best for you.



* Please be aware that some counties in the green and striped purple areas do not have provider coverage for either HMO Illinois or BlueAdvantage HMO; members in these counties may have access to the aforementioned health plan providers in a neighboring county. Please check with your provider for details.

Monthly Contributions

The Teachers' Retirement Insurance Program (TRIP) shares the cost of health coverage with you. While TRIP 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 | 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) | \$101.38 | \$314.92 | \$429.07 | \$124.46 |
| | Teachers Choice Health Plan (TCHP) | \$263.11 | \$734.96 | \$1,116.87 | \$295.10 |
| | TCHP when managed care is not available in your county | \$131.55 | \$367.48 | \$558.45 | \$147.56 |
| Dependent Beneficiary | Managed Care Plan (OAP and HMO) | \$405.68 | \$1,259.67 | \$1,716.24 | \$428.80 |
| | Teachers Choice Health Plan (TCHP) | \$526.24 | \$1,469.91 | \$2,233.75 | \$590.21 |
| | TCHP when managed care is not available in your county | \$526.24 | \$1,469.91 | \$2,233.75 | \$442.67 |

* You must enroll in both Medicare Parts A and B to qualify for the lower premiums. Send a copy of your Medicare card to TRS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit (see page 6).

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

Enrollment Opportunities

After the Benefit Choice Period ends, you will only be able to change your benefits if you have an enrollment opportunity.

You must report an enrollment opportunity at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) within 60 days of the event to be eligible to make benefit changes. Also note that it is required to report important events to the MyBenefits Service Center, including a change in Medicare status, marriage or divorce. To report a financial or medical power of attorney, contact your retirement system.

Please note: Members becoming Medicare-eligible will have a separate enrollment opportunity prior to their 65th birthday. Details can be found in the TRAIL section on Page 6.

Terminating TRIP Coverage

To terminate coverage at any time, please contact MyBenefits Service Center. 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 during an open enrollment period or other qualifying enrollment opportunity. Please refer to the Teachers' Retirement Insurance Program (TRIP) Handbook for other qualifying enrollment opportunities.

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 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 who are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, should contact their new plan administrator before July 1 to coordinate the transition of services for treatment.

HMO Benefits

Health Maintenance Organization (HMO) members are required to stay within the health plan provider network. No out-of-network services are available, other than listed below. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. For a copy of the SPD, contact the plan administrator (see page 7).

HMO Plan Design

| | | |
|---------------------------------|--------------------|----------------|
| Plan Year Out-of-Pocket Maximum | \$3,000 Individual | \$6,000 Family |
|---------------------------------|--------------------|----------------|

Hospital Services

| | In-Network | Out-of-Network |
|---------------------------------------|-------------------------------|-----------------|
| Emergency Room Services | \$200 copayment per visit | \$200 copayment |
| Inpatient Hospitalization | \$250 copayment per admission | Not covered |
| Inpatient Alcohol and Substance Abuse | \$250 copayment per admission | Not covered |
| Inpatient Psychiatric Admission | \$250 copayment per admission | Not covered |
| Outpatient Surgery | \$150 copayment per visit | Not covered |
| Skilled Nursing Facility | 100% covered | Not covered |
| Diagnostic Lab and X-ray | 100% covered | Not covered |

Transplant Services

| | |
|------------------------------|---|
| Organ and Tissue Transplants | \$250 copay, limited to network transplant facilities as determined by the medical plan administrator. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services. |
|------------------------------|---|

Professional and Other Services

| | In-Network | Out-of-Network |
|--|--------------------------|----------------|
| Preventive Care/Well-Baby/Immunizations | 100% covered | Not covered |
| Physician Office Visit | \$20 copayment per visit | Not covered |
| Specialist Office Visit | \$20 copayment per visit | Not covered |
| Telemedicine | \$10 copayment | Not covered |
| Outpatient Psychiatric and Substance Abuse | \$20 copayment per visit | Not covered |
| Durable Medical Equipment | 80% covered | Not covered |
| Home Health Care | \$15 copayment per visit | Not covered |

Prescription Drugs

Preventive Prescription Drugs – \$0

| | Reduced Tier I * | Tier I | Tier II | Tier III |
|----------------------------|------------------|--------|---------|----------|
| Copayments (30-day supply) | \$4 | \$10 | \$20 | \$40 |
| Copayments (90-day supply) | \$10 | \$25 | \$50 | \$100 |

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

Open Access Plan (OAP) Benefits

Open Access Plan (OAP) members will have three tiers of providers from which to choose to obtain services.

- **Tier I** offers a managed care network which provides enhanced benefits and operates like an HMO.
- **Tier II** offers an expanded network of providers and is a hybrid plan operating similar to an HMO and PPO.
- **Tier III** covers all providers which are not in the managed care networks of Tiers I or II (out-of-network providers). 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. For a copy of the SPD, contact the plan administrator (see page 7).

| Benefit | Tier I | Tier II | Tier III (Out-of-Network)** |
|---|---|--------------------|-----------------------------|
| Plan Year Out-of-Pocket Maximum | \$6,600 (includes eligible charges from Tier I and Tier II combined) | | Not Applicable |
| • Per Individual | \$13,200 (includes eligible charges from Tier I and Tier II combined) | | |
| • Per Family | | | |
| Plan Year Deductible (must be satisfied for all services) | \$0 | \$300 per enrollee | \$400 per enrollee* |

Hospital Services (Percentages listed represent how much is covered by the plan)

| | | | |
|---------------------------------------|-------------------------------|---|---|
| Emergency Room Services | \$200 copayment per visit | \$200 copayment per visit | \$200 copayment per visit |
| Inpatient Hospitalization | \$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 | \$250 copayment per admission | 80% of network charges after \$300 copayment per admission* | 60% of allowable charges after \$400 copayment per admission* |
| Inpatient Psychiatric Admission | \$250 copayment per admission | 80% of network charges after \$300 copayment per admission* | 60% of allowable charges after \$400 copayment per admission* |
| Outpatient Surgery | \$150 copayment per visit | 80% of network charges after \$150 copayment* | 60% of allowable charges after \$150 copayment* |
| Skilled Nursing Facility | 100% covered | 80% of network charges* | Not covered |
| Diagnostic Lab and X-ray | 100% covered | 80% of network charges* | 60% of allowable charges* |

Transplant Services

| | | | |
|------------------------------|---|--|--|
| Organ and Tissue Transplants | Tier I: 100% covered. Tier II: 80% of network charges. Tier III: Not covered. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services. | | |
|------------------------------|---|--|--|

Professional and Other Services

| | | | |
|--|------------------------|-------------------------|---------------------------|
| Preventive Care/Well-Baby /Immunizations | 100% covered | 100% covered | Not covered |
| Physician Office Visits | \$20 copayment | 80% of network charges* | 60% of allowable charges* |
| Specialist Office Visits | \$20 copayment | 80% of network charges* | 60% of allowable charges* |
| Telemedicine | \$10 copayment | Not covered | Not covered |
| Outpatient Psychiatric and Substance Abuse | \$20 copayment | 80% of network charges* | 60% of allowable charges* |
| Durable Medical Equipment | 80% of network charges | 80% of network charges* | 60% of allowable charges* |
| Home Health Care | \$15 copayment | 80% of network charges* | Not covered |

Prescription Drugs

Preventive Prescription Drugs – \$0

| | Tier I | Tier II | Tier III |
|---------------------------------------|--------|---------|----------|
| Copayments (30-day supply) | \$10 | \$20 | \$40 |
| Copayments (90-day supply) | \$20 | \$40 | \$80 |
| Maintenance Choice (90-day supply)*** | \$10 | \$20 | \$40 |

* 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.

Teachers' Choice Health Plan (TCHP) Benefits

Teachers' Choice Health Plan (TCHP) members may choose any physician or hospital for medical services; however, members receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a TCHP in-network provider. TCHP has a nationwide network of providers through Aetna PPO. 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 TCHP. For a copy of the SPD, contact the plan administrator (see page 7).

| Plan Year Deductible | |
|---|---|
| In-Network Individual \$500 per enrollee | Out-of-Network Individual \$500 per enrollee |

| Out-of-Pocket Maximum Limits | | | |
|----------------------------------|------------------------------|--------------------------------------|----------------------------------|
| In-Network Individual \$1,200 | In-Network Family \$2,750 | Out-of-Network Individual \$4,400 | Out-of-Network Family \$8,800 |

| Hospital Services (Percentages listed represent how much is covered by the plan) | | |
|--|---|--|
| | In-Network | Out-of-Network* |
| Emergency Room Services | \$400 per visit; Deductible applies | \$400 per visit; Deductible applies |
| Inpatient Hospitalization | 80% covered; Deductible applies after \$200 per admission | 60% of allowable charges; Deductible applies after \$400 per admission |
| Inpatient Alcohol and Substance Abuse | 80% covered; Deductible applies after \$200 per admission | 60% of allowable charges; Deductible applies after \$400 per admission |
| Inpatient Psychiatric Admission | 80% covered; Deductible applies after \$200 per admission | 60% of allowable charges; Deductible applies after \$400 per admission |
| Outpatient Surgery | 80% covered; Deductible applies | 60% of allowable charges; Deductible applies |
| Skilled Nursing Facility | 80% covered; Deductible applies | 60% of allowable charges; Deductible applies |
| Diagnostic Lab and X-ray | 80% covered; Deductible applies | 60% of allowable charges; Deductible applies |

| Transplant Services | |
|------------------------------|--|
| Organ and Tissue Transplants | 80% after \$200 transplant deductible, limited to network transplant facilities as determined by plan administrator. Not covered for out-of-network. Benefits not available unless approved by Notification Administrator. To assure coverage, contact Aetna prior to beginning evaluation services. |

| Professional and Other Services | | |
|--|------------------------------------|---------------------------------|
| | In-Network | Out-of-Network* |
| Preventive Care/Well-Baby/Immunizations | 100% covered | 60% covered; Deductible applies |
| Physician Office Visit | 80% covered; Deductible applies | 60% covered; Deductible applies |
| Specialist Office Visit | 80% covered; Deductible applies | 60% covered; Deductible applies |
| Telemedicine | \$10 copayment; Deductible applies | Does Not Apply |
| Outpatient Psychiatric and Substance Abuse | 80% covered; Deductible applies | 60% covered; Deductible applies |
| Durable Medical Equipment | 80% covered; Deductible applies | 60% covered; Deductible applies |
| Home Health Care | 80% covered; Deductible applies | 60% covered; Deductible applies |

| Prescription Drugs | | | |
|--|------------------------|------------------------|------------------------|
| Preventive Prescription Drugs – \$0 | | | |
| TCHP applies 20% coinsurance to the retail cost of the drug not to exceed the maximum copayment or be less than the minimum copayment. | | | |
| | Tier I | Tier II | Tier III |
| Copayments (30-day supply) | Greater of 20% or \$7 | Greater of 20% or \$14 | Greater of 20% or \$28 |
| Copayments (90-day supply) | Greater of 20% or \$14 | Greater of 20% or \$28 | Greater of 20% or \$56 |
| Maintenance Choice (90-day supply)** | Greater of 10% or \$14 | Greater of 10% or \$28 | Greater of 10% or \$56 |

* 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. Deductibles apply.



Teachers' Retirement 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 at a premium-free rate, TRIP requires that the benefit recipient enroll in Medicare benefits. Once enrolled, the benefit recipient is required to send a front-side copy of the Medicare identification card to the Teachers' Retirement System (TRS) (see page 7 for contact information).

Retirees are encouraged to enroll in Medicare Parts A and B in order to receive a reduced TRIP premium rate.

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 Teachers' Retirement System (TRS) 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.

State of Illinois Medicare COB Unit
PO Box 19208
Springfield, Illinois 62794-9208
CMS.Ben.MedicareCOB@illinois.gov
Fax: 217-557-3973

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 285655) Aetna OAP (Group Number 285651) Teachers' Choice Health Plan (TCHP) - Aetna PPO (Group Number 285659) 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 B06802) HMO Illinois (Group Number H06802) | 800-868-9520 866-876-2194 (TDD/TTY) | bcbsil.com/stateofillinois |
| | Blue Cross Blue Shield OAP (Group Number 263998) Address for all Blue Cross Plans: PO Box 805107, Chicago, IL 60680-4112 | 855-810-6537 | |
| | Health Alliance Medical Plans HMO (Group Number 2001741) 3310 Fields South Drive, Champaign, IL 61822 | 800-851-3379 800-526-0844 (TDD/TTY) | healthalliance.org/ stateofillinois |
| | HealthLink OAP (Group Number 160002) 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 TCHP or OAP Plans) Group Numbers: (TCHP 1402TD3) (Aetna OAP 1402TCH) (BCBSIL OAP TRIP=1402TCJ) (HealthLink OAP 1402TCF) 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 |
| Teachers' Retirement System (TRS) | 2815 West Washington Street PO Box 19253, Springfield, IL 62794-9253 | 877-927-5877 (877-9-ASK-TRS) 866-326-0087 (TDD/TTY) | trsil.org |



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 (TRIP) has determined that the prescription drug coverage it provides is Creditable Coverage. This means that the prescription coverage offered through TRIP 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 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 your TRIP coverage ends.

If you keep your existing group coverage through TRIP, 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 paper copy of the SBCs and glossary of terms from your health insurance company or group health plan. All TRIP health plan SBCs are available on [MyBenefits.illinois.gov](https://mybenefits.illinois.gov).

Notice of Privacy Practices

The Notice of Privacy Practices will be updated at [MyBenefits.illinois.gov](https://mybenefits.illinois.gov), effective July 1, 2022. 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](https://mybenefits.illinois.gov).

Notes

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal grey lines across its entire width, typical of notebook or school paper. The background is white, and there are no margins, text, or other markings present.



Illinois Department of
Central Management Services
Bureau of Benefits
PO Box 19208
Springfield, IL 62794-9208

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Benefit Choice Fair

The CMS-sponsored Benefit Choice Open Enrollment fair is currently scheduled for online webinar presentation in May. Date, time, and link to the scheduled event is listed below and open to all retired members not enrolled in an MAPD Plan. CMS representatives, as well as benefit vendors, available in your area, will be present during the webinar to answer questions. The Benefit Choice online fair session for TRIP members is scheduled for the following date and time:

[TRIP Members Virtual Benefit Choice Fair](#)

(Session Limited)

Tuesday, May 10, 2022, 10:00 AM - 12:00 PM

