Benefit Highlights

Illinois Department of Central Management Services
College Insurance Program (CIP) 12808
Effective January 1, 2021 to December 31, 2021

This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs

	In-Network	Out-of-Network
Annual medical deductible	Your plan has an annual combined in-network and out-of-network medical deductible of $250 each plan year.	
Annual medical out-of-pocket maximum (The most you pay in a plan year for covered medical care)	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,100 each plan year.	

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Doctor's office visit	Primary Care Provider: 20% coinsurance	Primary Care Provider: 20% coinsurance
	Specialist: 20% coinsurance	Specialist: 20% coinsurance
	Virtual Doctor Visits: $0 copay	Virtual Doctor Visits: $0 copay
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Evidence of Coverage for additional information.	
Inpatient hospital care	20% coinsurance per stay	20% coinsurance per stay
Skilled nursing facility (SNF)	20% coinsurance per day	20% coinsurance per day
	Our plan covers unlimited days in a SNF per benefit period.	
Outpatient surgery	20% coinsurance	20% coinsurance
Outpatient rehabilitation (physical, occupational, or speech/language therapy)	20% coinsurance	20% coinsurance
Mental health (outpatient and virtual)	Group therapy: 20% coinsurance	Group therapy: 20% coinsurance
	Individual therapy: 20% coinsurance	Individual therapy: 20% coinsurance
	Virtual visits: 20% coinsurance	Virtual visits: 20% coinsurance
Diagnostic radiology services (such as MRIs, CT scans)	20% coinsurance	20% coinsurance

Medical Benefits

Benefits covered by Original Medicare and your plan

	In-Network	Out-of-Network
Lab services	20% coinsurance	20% coinsurance
Outpatient x-rays	20% coinsurance	20% coinsurance
Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance	20% coinsurance
Ambulance	20% coinsurance	20% coinsurance
Emergency care	$120 copay (worldwide)	
Urgently needed services	20% coinsurance (worldwide)	20% coinsurance (worldwide)

Additional benefits and programs not covered by Original Medicare

	In-Network	Out-of-Network
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Foot care - routine	20% coinsurance (Up to 6 visits per plan year)*	20% coinsurance (Up to 6 visits per plan year)*
Hearing - routine exam**	$0 copay (1 exam every 2 plan years)	$0 copay (1 exam every 2 plan years)
Hearing aids**	Through UnitedHealthcare Hearing, the plan pays up to a $2,500 allowance for hearing aids per ear every 2 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing.	Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.
Fitness program through SilverSneakers®	You have access to SilverSneakers®, a Medicare fitness program. SilverSneakers inludes a $0 membership fee for a standard, monthly membership at a participating fitness center. To get your SilverSneakers ID number or learn more about this benefit, visit SilverSneakers.com or call 1-888-423-4632, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.	
NurseLine	Receive access to nurse consultations and additional clinical resources at no additional cost.	

*Benefits are combined in and out-of-network

** The hearing exam copayment and hearing aid allowance do not apply to your annual medical deductible so you may receive these benefits prior to meeting the deductible. The copayment and allowance for these benefits do not count toward your annual out-of-pocket maximum. Any out-of-pocket expenses for these benefits over the copayment and allowance are your responsibility.

Prescription Drugs

	Your Cost

Initial Coverage Stage	Network Pharmacy (30-day retail supply)	Network Pharmacy (31 to 60-day retail supply)	Network Pharmacy (61 to 90-day retail supply)
Tier 1: Preferred Generic	$10 copay	$20 copay	$30 copay
Tier 2: Preferred Brand	$25 copay	$50 copay	$75 copay
Tier 3: Non-preferred Drug	$50 copay	$100 copay	$150 copay
Tier 4: Specialty Tier	$50 copay	$100 copay	$150 copay

	Your Cost		
Initial Coverage Stage	**Mail Order Pharmacy (30-day supply)**	**Mail Order Pharmacy (31 to 60-day supply)**	**Mail Order Pharmacy (61 to 90-day supply)**
Tier 1: Preferred Generic	$10 copay	$20 copay	$25 copay
Tier 2: Preferred Brand	$25 copay	$50 copay	$62.50 copay
Tier 3: Non-preferred Drug	$50 copay	$100 copay	$125 copay
Tier 4: Specialty Tier	$50 copay	$100 copay	$125 copay
Coverage Gap stage (after your prescription costs reach $4,130)	The plan covers all formulary drugs through the coverage gap at the same copays listed above.		
Catastrophic coverage stage (after you have paid $6,550 out-of-pocket)	For up to a 30-day, 60-day or 90-day supply: You pay the greater of either 5% coinsurance (not to exceed $50) or $3.70 copay for generic or $9.20 copay for brand.		

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your drug list (formulary). Please see your Additional Drug Coverage list for more information. Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change each plan year.
The Drug List (Formulary), pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.