



STATE OF ILLINOIS
Department of Central Management Services
Bureau of Benefits

FY 2026

benefit choice



State Employees Group Insurance Program

Benefit Choice Period

May 1 - June 2, 2025

Effective July 1, 2025



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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 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 - June 2, 2025.
3. 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, 2025.

Note: If you are not currently enrolled in benefits due to previous nonpayment of premiums, contact the Premium Collection Unit at 217-558-4783 to discuss your enrollment options.

DISCLAIMER

Monthly health insurance contributions are based on your March 1st salary, or initial salary for new hires. Your monthly contribution amount reflected within this site is based on the salary reported on your paycheck for the first pay period in March, and will be adjusted as necessary, if updated information is provided.

Benefit Choice Period

Elect Your Benefits May 1 - June 2, 2025

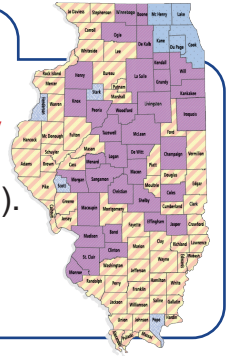
What's New

! Health Alliance: Action Required

Effective July 1, 2025, Health Alliance will no longer be an available option. If you are currently enrolled in Health Alliance and you do not select a new plan, you will be defaulted to the Quality Care Health Plan (QCHP) for the FY2026 Benefit Period.

! Health Plan Availability

There are several changes this year. It is **your responsibility** to verify what Health Plans are available in your area (see page 2).



Medicare Split Family

Attention - Retirees, Annuitants, & Survivors

There is a **VERY IMPORTANT** change in the required Total Retiree Advantage Illinois (TRAIL) Medicare Advantage Prescription Drug (MAPD) enrollment effective July 1, 2025.

As a retiree, you and any covered dependents are required to apply for Medicare insurance benefits. Those retirees eligible for premium-free Medicare Part A are required to enroll in both Medicare Part A and Part B. Failure to enroll in these benefits will result in a reduction of eligible claim benefits.

New Starting July 1, 2025

Retired members and dependents who are eligible to enroll in Medicare Parts A and B are also required to enroll in a TRAIL Medicare Advantage Prescription Drug (MAPD) Program. Effective July 1, 2025, you or your dependent will be required to enroll in the TRAIL MAPD plan when you are first eligible for Medicare, either by age or disability.

If you currently cover **2 or more dependents**, you nor your Medicare eligible dependent(s) will be required to enroll in the TRAIL MAPD plan **until** there is only one covered dependent remaining or all covered dependents are Medicare eligible.

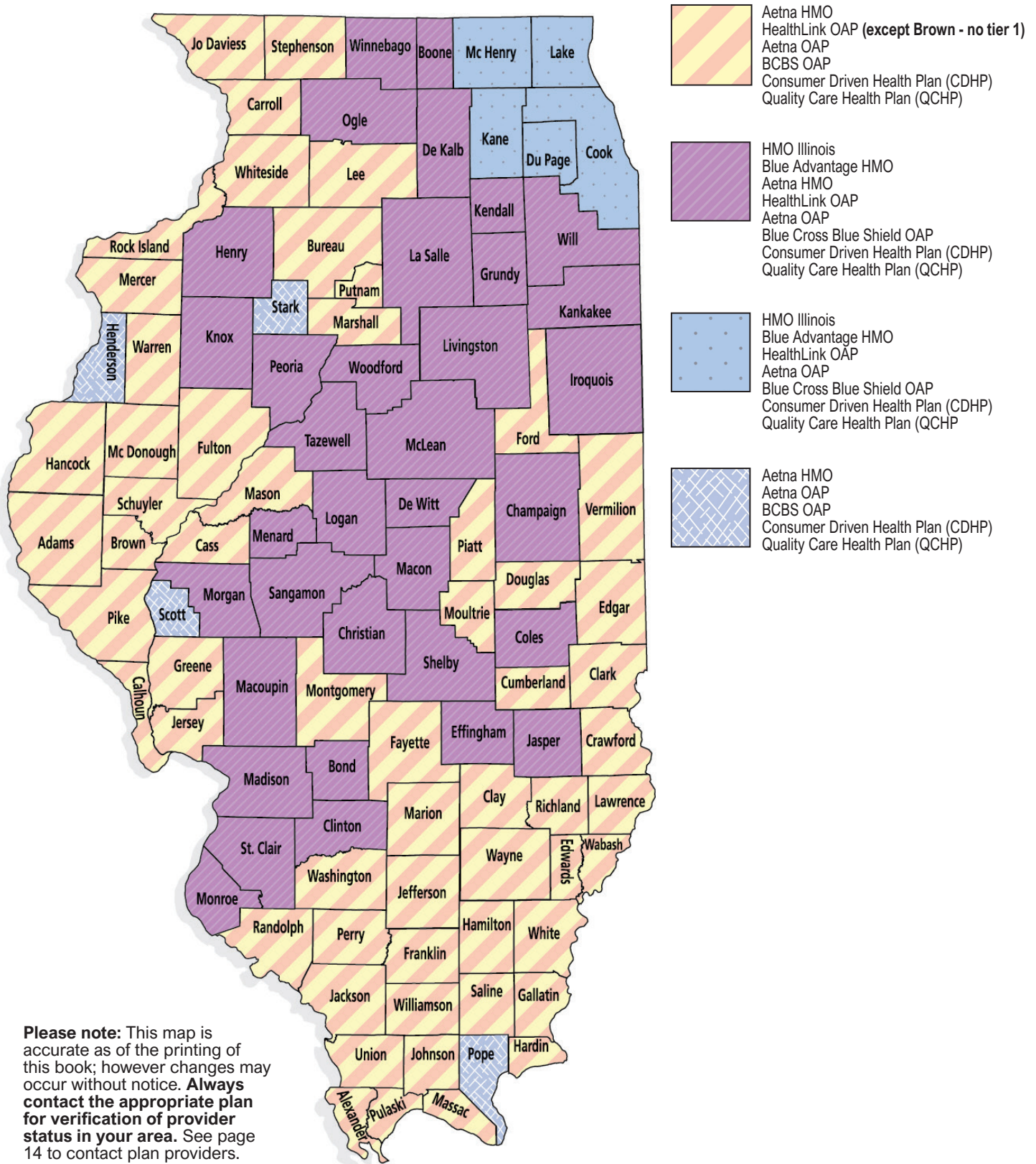
What do you need to do?

- During this Benefit Choice Open Enrollment period (May 1 – June 2, 2025), the Medicare eligible member or dependent will be required to enroll in the TRAIL MAPD plan for coverage to be effective July 1, 2025. If the member is eligible, failure to enroll will result in the termination of coverage for the member and any covered dependents. If the dependent is eligible, failure to enroll will result in the termination of the dependent's coverage.

More information on this change will be available at the Benefit Choice Member Fairs (Dates/Times/Locations are listed on the back of this booklet)

What is Available in Your Area in FY26

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.



Monthly Contributions

The State shares the cost of health coverage with you. While the State covers most of the cost, you must make monthly contributions determined by your annual salary. The following charts outline monthly contribution rates for full-time members. Part-time members are required to pay a percentage of the State's portion of the monthly contribution in addition to their own. Special rules apply for non-IRS dependents (see [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) for more information).

Employee Annual Salary	Aetna HMO	Blue Advantage	HMO Illinois	Aetna OAP	BCBSIL OAP *	HealthLink OAP	CDHP **	QCHP ***
\$30,200 & below	\$138	\$112	\$116	\$132	\$132	\$146	\$113	\$152
\$30,201 - \$45,600	\$157	\$131	\$135	\$151	\$151	\$165	\$132	\$171
\$45,601 - \$60,700	\$176	\$150	\$154	\$170	\$170	\$184	\$151	\$189
\$60,701 - \$75,900	\$194	\$168	\$172	\$188	\$188	\$202	\$169	\$208
\$75,901 - \$100,000	\$213	\$187	\$191	\$207	\$207	\$221	\$188	\$227
\$100,001 - \$125,000	\$267	\$241	\$245	\$261	\$261	\$275	\$242	\$281
\$125,001 - and over	\$300	\$274	\$278	\$294	\$294	\$308	\$275	\$314

Members who retire, accept a salary reduction, or return to State employment at a different salary may have their monthly contribution adjusted based upon the new salary. This applies to members who return to work after having a 10-day or greater break in State service after terminating employment. This does not apply to members who have a break in coverage due to a leave of absence.

Dependent Monthly Health Plan Contributions

In addition to monthly contributions for their own health coverage, members must make additional monthly contributions for dependents they cover. Dependents must be enrolled in the same plan as the member. The Medicare dependent monthly contribution applies only if the member is a retiree or annuitant and Medicare is primary for both Parts A and B.

Number of Dependents	Aetna HMO	Blue Advantage	HMO Illinois	Aetna OAP	BCBSIL OAP *	HealthLink OAP	CDHP **	QCHP ***
1 Dependent	\$205	\$168	\$172	\$196	\$196	\$214	\$179	\$301
2+ Dependent	\$250	\$204	\$211	\$241	\$241	\$267	\$223	\$339
1 Medicare A & B Primary Dependent	\$182	\$147	\$151	\$173	\$173	\$190	\$156	\$194
2+ Medicare A & B Primary Dependents	\$224	\$182	\$188	\$215	\$215	\$237	\$197	\$255

DISCLAIMER

Retiree, annuitant, and survivor contributions for all health plan options will be in accordance with the levels set forth above in FY26. For future years, the State reserves the right to designate the plan options which constitute the basic program of health benefits and to require additional contributions in accordance with the law for any optional coverage elected by an annuitant, retiree, or survivor.

* BCBSIL OAP = Blue Cross Blue Shield of Illinois

** CDHP = Consumer Driven Health Plan

*** QCHP = Quality Care Health Plan

Adding a Dependent

If you add a dependent for the first time, or re-enroll a dependent during open enrollment, you must provide the required documentation to complete enrollment no later than June 12, 2025. Failure to provide adequate documentation by this deadline, will result in dependents not being added to your plan. Note: Any documentation received after June 2, 2025, may result in a delay of ID cards.

Opt-Out

Full-time employees, retirees, annuitants, and survivors have the option to opt-out of health coverage if they have other comprehensive coverage provided by an entity other than the Department of Central Management Services. Be advised that if you have previously opted out, or waived benefits, you can re-enroll during the Benefit Choice Period or if you experience a Qualifying Change in Status.

Transition of Care after Health Plan Change

Members and their dependents who elect to change health plans and are then hospitalized prior to July 1, 2025 and discharged on or after July 1, 2025, 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, 2025 to coordinate the transition of services.

State Employees Group Insurance Program

Medicare Requirements

Retirees and survivors must apply for Medicare benefits upon turning age 65. If the Social Security Administration (SSA) determines that the member and/or dependent is eligible for Medicare Part A and/or Part B, the member and/or dependent is required by the State to enroll in Medicare Parts A and B. Those on a disability leave are also required to apply for Medicare Part A and B. Once enrolled in Medicare, the member and/or dependent is required to fax or email the front-side copy of the Medicare identification card to the State of Illinois Medicare COB Unit (contact information below).

If the SSA determines that a member and/or dependent is not eligible for premium-free Medicare Part A based on their own work history or the work history of a spouse (current, ex-spouse or deceased) at least 62 years of age, the member 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.

For more information regarding the Medicare Advantage Prescription Drug “TRAIL” Program, go to <https://cms.illinois.gov/benefits/trail.html>, or contact:

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

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 14).

HMO Plan Design

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

	In-Network	Out-of-Network
Emergency Room Services	\$275 copayment per visit	\$275 copayment per visit
Inpatient Hospitalization	\$475 copayment per admission	Not covered
Inpatient Alcohol and Substance Abuse	\$475 copayment per admission	Not covered
Inpatient Psychiatric Admission	\$475 copayment per admission	Not covered
Outpatient Surgery	\$350 copayment per visit	Not covered
Skilled Nursing Facility	100% covered	Not covered
Diagnostic Lab and X-ray	100% covered	Not covered
Complex Imaging (CT/Pet Scans/MRIs)	\$30 copayment	Not covered

Transplant Services

Organ and Tissue Transplants	\$375 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.
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Professional and Other Services

	In-Network	Out-of-Network
Preventive Care/Well-Baby/Immunizations	100% covered	Not covered
Physician Office Visit	\$30 copayment per visit	Not covered
Specialist Office Visit	\$40 copayment per visit	Not covered
Telemedicine	\$10 copayment	Not covered
Outpatient Psychiatric and Substance Abuse	\$30 or \$40 copayment per visit	Not covered
Durable Medical Equipment	80% covered	Not covered
Home Health Care	\$40 copayment per visit	Not covered
Complex Imaging (CT/Pet Scans/MRIs)	\$30 copayment	Not covered

Prescription Drugs

Plan Year Pharmacy Deductible – \$150 per enrollee		Preventive Prescription Drugs – \$0		
	Reduced Tier I *	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$4.00	\$20.00	\$35.00	\$60.00
Copayments (90-day supply)	\$10.00	\$50.00	\$87.50	\$150.00

* Applies to specific medications as defined by the 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 similar to an HMO.
- **Tier II** offers an expanded network of providers and is a hybrid plan operating like 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). It is the member's responsibility to know and follow the specific requirements of the OAP. Benefits are outlined in the plan's Summary Plan Document (SPD). For a copy of the SPD, contact the plan administrator (see page 14).

Benefit	Tier I	Tier II	Tier III (Out-of-Network)**
Plan Year Out-of-Pocket Maximum • Per Individual • Per Family	\$3,000 (includes eligible charges from Tiers I & II combined) \$6,000 (includes eligible charges from Tiers I & II combined)		Not Applicable
Plan Year Deductible (must be satisfied for all services)	\$0	\$325 per enrollee*	\$425 per enrollee*

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

Emergency Room Services	\$275 copayment per visit	\$275 copayment per visit	\$275 copayment per visit
Inpatient Hospitalization	\$475 copayment per admission	90% of network charges after \$525 copayment per admission*	60% of allowable charges after \$625 copayment per admission*
Inpatient Alcohol and Substance Abuse	\$475 copayment per admission	90% of network charges after \$525 copayment per admission*	60% of allowable charges after \$625 copayment per admission*
Inpatient Psychiatric Admission	\$475 copayment per admission	90% of network charges after \$525 copayment per admission*	60% of allowable charges after \$625 copayment per admission*
Outpatient Surgery	\$350 copayment per visit	90% of network charges after \$350 copayment*	60% of allowable charges after \$350 copayment*
Skilled Nursing Facility	100% covered	90% of network charges*	Not covered
Diagnostic Lab and X-ray	100% covered	90% of network charges*	60% of allowable charges*
Complex Imaging (CT/Pet Scans/MRIs)	\$30 copayment	90% of network charges*	60% of allowable charges*

Transplant Services

Organ and Tissue Transplants	Tier I: 100% covered. Tier II: 90% of network charges. Tier III: Not covered. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services.		
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Professional and Other Services

Preventive Care/Well-Baby /Immunizations	100% covered	100% covered	Not covered
Physician Office Visits	\$30 copayment	90% of network charges*	60% of allowable charges*
Specialist Office Visits	\$40 copayment	90% of network charges*	60% of allowable charges*
Telemedicine	\$10 copayment	Not covered	Not covered
Outpatient Psychiatric and Substance Abuse	\$30 or \$40 copayment	90% 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	\$40 copayment	90% of network charges*	Not covered

Prescription Drugs

Plan Year Pharmacy Deductible – \$150 per enrollee Preventive Prescription Drugs – \$0

	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$20.00	\$35.00	\$60.00
Copayments (90-day supply)***	\$50.00	\$87.50	\$150.00
Maintenance Choice (90-day supply)****	\$25.00	\$43.75	\$75.00

* 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.

*** If a member or dependent elects a higher Tier drug where a lower Tier drug is available, the member or dependent is responsible for the higher copayment plus the difference in cost between the drugs.

**** Medications received at CVS Caremark® Retail Pharmacy or through CVS Caremark® Mail Service Pharmacy.

Quality Care Health Plan (QCHP) Benefits

Quality Care Health Plan (QCHP) members may choose any physician or hospital for medical services; however, when receiving services from a QCHP in-network provider, members receive enhanced benefits, resulting in lower out-of-pocket costs. QCHP 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 QCHP. For a copy of the SPD, contact the plan administrator (see page 14).

Plan Year Maximums and Deductibles

Employee's Annual Salary (based on each employee's annual salary as of March 1st)	Individual Plan Year Deductible	Family Plan Year Deductible Cap
\$60,700 or less	\$450	\$1,125
\$60,701 - \$75,900	\$550	\$1,375
\$75,901 and more	\$600	\$1,500
Retiree/Annuitant/Survivor	\$450	\$1,125
Dependents	\$450	N/A

Out-of-Pocket Maximum Limits

In-Network Individual \$1,750	In-Network Family \$4,375	Out-of-Network Individual \$7,000	Out-of-Network Family \$13,500
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Hospital Services (Percentages listed represent how much is covered by the plan)

	In-Network	Out-of-Network*
Emergency Room Services	\$450 per visit; Deductible applies	\$450 per visit; Deductible applies
Inpatient Hospitalization	85% of network charges; Deductible applies after \$250 per admission	60% of allowable charges; Deductible applies after \$850 per admission
Inpatient Alcohol and Substance Abuse	85% of network charges; Deductible applies after \$250 per admission	60% of allowable charges; Deductible applies after \$850 per admission
Inpatient Psychiatric Admission	85% of network charges; Deductible applies after \$250 per admission	60% of allowable charges; Deductible applies after \$850 per admission
Outpatient Surgery	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Skilled Nursing Facility	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Complex Imaging (CT/Pet Scans/MRIs)	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies

Transplant Services

Organ and Tissue Transplants	85% 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. To assure coverage, contact Aetna prior to beginning evaluation services.
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Professional and Other Services

	In-Network	Out-of-Network*
Preventive Care/Well-Baby/Immunizations	100% covered	60% of allowable charges; Deductible applies
Physician Office Visit	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Specialist Office Visit	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Telemedicine	85% of network charges; Deductible applies	Does Not Apply
Outpatient Psychiatric and Substance Abuse	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Durable Medical Equipment	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies
Home Health Care	85% of network charges; Deductible applies	60% of allowable charges; Deductible applies

Prescription Drugs

Plan Year Pharmacy Deductible – \$175 per enrollee

Preventive Prescription Drugs – \$0

	Tier I	Tier II	Tier III
Copayments (30-day supply)	\$20.00	\$40.00	\$65.00
Copayments (90-day supply)	\$50.00	\$100.00	\$162.50
Maintenance Choice (90-day supply)**	\$25.00	\$50.00	\$81.25

* 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® Retail Pharmacy or through CVS Caremark® Mail Service Pharmacy.

Consumer Driven Health Plan (CDHP) Benefits

This is a high-deductible health plan as defined by the IRS. Consumer Driven Health Plan (CDHP) members may choose any physician or hospital for medical services; however, when receiving services from a CDHP in-network provider, members receive enhanced benefits, resulting in lower out-of-pocket costs. CDHP has a nationwide network of providers through Aetna PPO. CDHP is available for active employees only, under the State Employees' Group Insurance Program. This plan is not available to retirees. 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 CDHP. For a copy of the SPD, contact the plan administrator (see page 14).

Plan Year Medical Deductibles			
In-Network Individual \$1,650	In-Network Family \$3,300	Out-of-Network Individual \$1,650	Out-of-Network Family \$3,300

Out-of-Pocket Maximum Limits			
In-Network Individual \$3,000	In-Network Family \$6,000	Out-of-Network Individual \$3,000	Out-of-Network Family \$6,000

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

	In-Network	Out-of-Network*
Emergency Room Services	90% of coinsurance; Deductible applies	90% of coinsurance; Deductible applies
Inpatient Hospitalization	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Inpatient Alcohol and Substance Abuse	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Inpatient Psychiatric Admission	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Outpatient Surgery	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Skilled Nursing Facility	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Diagnostic Lab and X-ray	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Complex Imaging (CT/Pet Scans/MRIs)	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies

Transplant Services

Organ and Tissue Transplants	90% after plan year deductible, limited to network transplant facilities as determined by the medical plan administrator. Not covered out-of-network. Benefits are not available unless approved by the Notification Administrator. To assure coverage, contact Aetna prior to beginning evaluation services.
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Professional and Other Services

	In-Network	Out-of-Network*
Preventive Care/Well-Baby/Immunizations	100% covered	65% of allowable charges; Deductible applies
Preventive Services (IRS-allowed)**	90% of network charges; No Deductible	65% of allowable charges; Deductible applies
Physician Office Visit	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Specialist Office Visit	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Telemedicine	90% of network charges; Deductible applies	Does Not Apply
Outpatient Psychiatric and Substance Abuse	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Durable Medical Equipment	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies
Complex Imaging (CT/Pet Scans/MRIs)	90% of network charges; Deductible applies	65% of allowable charges; Deductible applies

Prescription Drugs

Preventive Prescription Drugs – \$0 Preventive Prescription Drugs (IRS-allowed) **

90% covered; No Deductible			
	Tier I	Tier II	Tier III
Copayments (30-day supply)	90%; Deductible Applies	90%; Deductible Applies	90%; Deductible Applies
Copayments (90-day supply)	90%; Deductible Applies	90%; Deductible Applies	90%; Deductible Applies
Maintenance Choice (90-day supply)***	95%; Deductible Applies	95%; Deductible Applies	95%; Deductible Applies

* 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.

** Contact Aetna for IRS-allowed services and prescriptions.

*** Medications received at CVS Caremark® Retail Pharmacy or through CVS Caremark® Mail Service Pharmacy.

Medical Care Assistance Program (MCAP) - Companion to your HMO, OAP, QCHP, or CDHP (if not enrolled in an HSA)

EMPLOYEES MUST RE-ENROLL EACH PLAN YEAR

The MCAP maximum contribution limit is \$3,300 for the FY26 plan year period. Funds must be used within the plan year, July 1, 2025 - June 30, 2026. All claims and documentation must be submitted and approved by September 30, 2026. The rollover of unused FY26 funds will be capped at \$660.00. Participants who do not re-enroll for the new plan year will forfeit any amount eligible for rollover.

Dependent Care (Day Care) Assistance Program (DCAP)

DCAP is an account that allows you to set aside pre-tax contributions per pay period to pay for dependent care (Day Care) expenses, for children aged 12 and under, or care for a physically or mentally disabled dependent. DCAP cannot be used for dependent medical expenses or for children for which you are not considered the primary or custodial parent. The DCAP maximum contribution limit is \$5,000 for the FY26 plan year period. Any unused DCAP funds at the end of the plan year will be forfeited.

Health Savings Accounts (HSA) for Active State Employees - Companion to CDHP Enrollment ONLY

EMPLOYEE CONTRIBUTION MUST BE RE-ELECTED EACH PLAN YEAR

An HSA is like a 401(k) for healthcare, yet the HSA tax benefits are far greater. Administered by Optum Financial, the HSA is a tax-favored, interest-bearing account that active State employees can use to pay for qualified medical expenses now, or in the future. Active State employees who qualify (see Qualifying for an HSA below), can save, or invest the account funds. Paired with the Consumer Driven Health Plan (CDHP), an HSA is a powerful financial tool that gives you more control of your healthcare decisions.

The State will contribute a third of the deductible to an active State employee's HSA. Maximum HSA contributions (Employer + Employee) for FY26 will be:

Under Age 55			Aged 55 and older		
	Individual	Family		Individual	Family
Employer Contribution =	\$550	\$1,100	Employer Contribution =	\$550	\$1,100
Employee Contribution =	\$3,750	\$7,450	Employee Contribution =	\$4,750	\$8,450
Max IRS Allowed Contribution =	\$4,300	\$8,550	Max IRS Allowed Contribution =	\$5,300	\$9,550

Contributions to your HSA can be made through pre-tax payroll deductions or post-tax direct payment. Active State employees can make tax-free withdrawals to pay for qualified medical expenses, for you and your eligible dependents. HSAs are portable and all contributions rollover to the next plan year. If the employee invests HSA funds, those funds remain in the investment account. HSAs may be used for future healthcare expenses including out-of-pocket expenses after retirement, Medicare, and long-term care (LTC) premiums, up to IRS limits and certain LTC expenses. There are no income limitations.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must:

- Be covered under a high-deductible health plan.
- Have no other health coverage (except what is permitted under Other health coverage: https://www.irs.gov/publications/p969#en_US_2019_publink1000204039)
- Not be enrolled in Medicare. This includes Part A.
- Not be claimed as a dependent on someone else's tax return.
- Complete the Customer Identification Program through OPTUM Financial

You cannot be enrolled in BOTH an HSA and MCAP Flexible Spending Account.

Vision

Vision coverage is provided at no cost to all members enrolled in a State health plan and is administered by EyeMed. All enrolled members and dependents receive the same vision coverage regardless of the health plan selected.

Service	In-Network	Out-of-Network**	Benefit Frequency
Eye Exam	\$30 copayment	\$30 allowance	Once every 12 months
Standard Frames	\$30 copayment (up to \$175 retail frame cost; member responsible for balance over \$175)	\$70 allowance	Once every 24 months
Vision Lenses* (single, bifocal and trifocal)	\$30 copayment	\$50 allowance for single vision lenses. \$80 allowance for bifocal and trifocal lenses	Once every 12 months
Contact Lenses (All contact lenses are in lieu of vision lenses)	\$120 allowance	\$120 allowance	Once every 12 months

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

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

Additional Vision Benefits

EyeMed offers additional coverage for Progressive Lenses, Premium Anti-Reflective Coating, and coverage for Photochromic and Polarized lenses. For more information on this program visit eyemedvisioncare.com/stil or contact EyeMed at 1-866-723-0512



Dental

Employees have the option to enroll in Dental Only coverage. However, if you enroll in health coverage and choose dental coverage, dependents must mirror the coverage of the member.

The State's Quality Care Dental Plan (QCDP) offers a comprehensive range of benefits and is available to all members and is administered by Delta Dental of Illinois. Visit [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) for a Dental Schedule of Benefits.

Deductible and Plan Year Maximum

Plan year deductible for preventive services	N/A
Plan year deductible for all other covered services	\$175
Plan Year Maximum Benefit (Orthodontics + All Other Covered Expenses = Maximum Benefit)	
In-network plan year maximum benefit	\$2,500
Out-of-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.

Enhanced Delta Dental Benefits Program

The Delta Dental of Illinois' Enhanced Benefits Program integrates medical and dental care – where oral health meets overall health. This program enhances coverage for individuals who have specific health conditions that can be positively affected by additional oral health care. These enhancements are based on scientific evidence that shows treating and preventing oral disease in these situations can improve overall health. For more information on this program visit www.deltadentalil.com or contact Delta Dental at 1-800-323-1743.

Child Orthodontia Benefit

Length of Orthodontia Treatment*	Maximum Benefit	
	In-Network	Out-of-Network
0 - 36 Months	\$2,000	\$1,500
0 - 18 Months	\$1,820	\$1,364
0 - 12 Months	\$1,040	\$780

Member Monthly Quality Care Dental Plan (QCDP) Contributions**

Member Only	Member + 1 Dependent	Member + 2 or More Dependents
\$16.00	\$27.00	\$29.50

* Orthodontia Treatments must start prior to age 19.

** Part-time employees are required to pay a percentage of the State's portion of the contribution in addition to the member contribution. Special rules apply for non-IRS dependents (see [MyBenefits.illinois.gov](https://mybenefits.illinois.gov) for more information).



Life Insurance

Basic Life Insurance coverage is provided by MetLife at no cost to all active employees, retirees, and annuitants through the State Employees Group Insurance Program.

- Active employees, retirees, and annuitants under the age of 60, receive a benefit amount equal to their annual salary.
- Retirees and annuitants, age 60 or older, receive a \$5,000 benefit.

Member Optional Life coverage is provided at a cost to all active employees, retirees, and immediate annuitants.

- For active employees, and retirees and immediate annuitants under age 60 – coverage is available up to 8 times their Basic Life amount.
- For retirees and immediate annuitants aged 60 or older – coverage is available up to 4 times their Basic Life amount.

The maximum benefit allowed for Member Optional Life plus Basic Life is \$3,000,000. Rate changes due to age will be effective the first pay-period following the member's birthday.

Optional Term Life Rate	
Member Age	Monthly Rate Per \$1,000
Under 30	\$0.03
30-39	\$0.05
40-44	\$0.09
45-49	\$0.12
50-54	\$0.19
55-59	\$0.36
60-64	\$0.56
65-69	\$1.26
70 and Over	\$2.06

Accidental Death & Dismemberment (AD&D) coverage is available to eligible members in an amount equal to either their Basic Life amount or the combined amount of their Basic and Member Optional Life. This coverage is subject to a total maximum of 5 times the Basic Life amount or \$3,000,000, whichever is less.

AD&D Monthly Rate per \$1,000
\$0.02

Beneficiary Elections

Don't forget to elect your beneficiaries at metlife.com/stateofillinois/ and make the appropriate updates when necessary to ensure that your Life Insurance benefit is paid out according to your wishes. Remember, you may also have death benefits through various state-sponsored programs, each having a separate beneficiary form, including Life Insurance, retirement benefits, and the Deferred Compensation Program.

Spouse life coverage is available for:

- The spouse of an active employee.
- The spouse of a retiree or an annuitant.

The lump sum amount is either \$10,000 or \$5,000 depending upon the spouse's age

Spouse Life Monthly Rates	
Spouse Life \$10,000 Coverage (Spouse under age 60)	\$5.70
Spouse Life \$5,000 Coverage (Spouse age 60 or older)	\$2.85

Note: Rate changes due to age will be effective the first day of the pay period following the **spouse's** birthday.

Child life coverage is available in a lump sum amount of \$10,000 per child to active employees, retirees, and immediate annuitants. The monthly contribution applies to all dependent children regardless of the number of children enrolled. Eligible children include children aged 25 and under or, children in the disabled category.

Child Life Monthly Rate	
Child Life \$10,000 Coverage	\$0.60

Note: Deferred Annuitants are not eligible for Member Optional Life, AD&D, Child Life or Spouse Life Coverage.

Underwriting

A Statement of Health (SOH) is required for members to add/increase optional life or to add Spouse Life (unless you are a new hire, or this is a newly acquired spouse/civil union partner). A Statement of Health is not needed to add Child Life coverage or AD&D.



The State of Illinois' ongoing comprehensive approach to wellness.

The State of Illinois cares about you and your health.

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

Be Well Featured Resources



[Awareness Matters](#)



[Wellness Webinars](#)



[Financial Wellness](#)



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[Food For Thought](#)



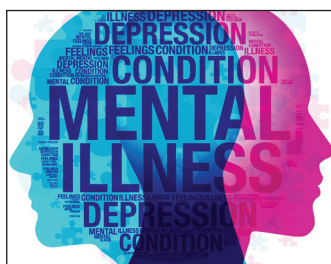
[Get Moving](#)



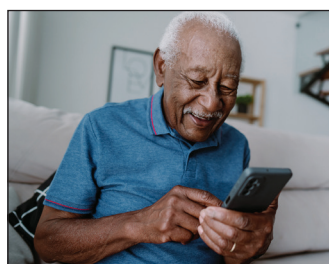
[Kid's Corner](#)



[Healthcare Resources](#)



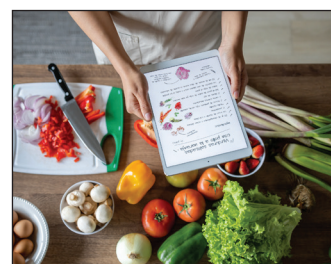
[Mental Health Resources](#)



[Retiree Wellness](#)



[Women's Health Resources](#)



[BeWell Recipes](#)

Contacts

Purpose	Administrator Name and Address	Phone	Website
Enrollment	MyBenefits – MyBenefits Service Center (MBSC) P.O. Box 9927, Providence, RI 02940-4027	844-251-1777 844-251-1778 (TDD/TTY)	mybenefits.illinois.gov
Health Plan	Aetna HMO (Group Number 285654) Aetna OAP (Group Number 285650) Consumer Driven Health Plan (CDHP) - Aetna PPO (Group Number 285658) Quality Care Health Plan (QCHP) - Aetna PPO (Group Number 285658) 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 B06800) HMO Illinois (Group Number H06800) Blue Cross Blue Shield OAP (Group Number 263995) Address for all Blue Cross Plans: PO Box 805107, Chicago, IL 60680-4112	800-868-9520 866-876-2194 (TDD/TTY) 855-810-6537	bcbsil.com/stateofillinois
	HealthLink OAP (Group Number 160000) 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 QCHP, CDHP, or OAP Plans) Group Numbers: (QCHP 1400SD3) (CDHP 1400SD9) (Aetna OAP 1400SCH) (BCBSIL OAP 1400SCJ) (HealthLink OAP 1400SCF) 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 20240) PO Box 5402, Lisle, IL 60532	800-323-1743 800-526-0844 (TDD/TTY)	soi.deltadentalil.com
Life Insurance	MetLife Insurance Company, Group Life Claims PO Box 6100, Scranton, PA 18505	800-880-6394 TTY users, call 711	metlife.com/stateofillinois
Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA)	Optum Financial PO Box 622317, Orlando, FL 32862-2317	888-469-3363 800-526-0844 (TDD/TTY) 443-681-4602 (fax)	Optumfinancial.com
Commuter Savings Program (CSP)	Edenred Benefits Claims Administrator 265 Winter Street, 3rd Floor, Waltham, MA 02451	888-235-9223 844-878-0594 (TDD/TTY)	login.commuterbenefits.com/
Employee Assistance Program (EAP)	ComPsych Corporation 455 N. Cityfront Plaza Drive, Chicago, IL 60611	833-955-3400 800-697-0353 (TDD/TTY)	guidanceresources.com ComPsych Member Web ID Code: StateofIllinois
Personal Support Program (PSP – AFSCME EAP)	AFSCME Council 31 205 N Michigan 2100, Chicago, IL 60601	800-647-8776 (statewide) 800-526-0844 (TDD/TTY)	afscme31.org
State Employees' Retirement System	2101 South Veterans Parkway PO Box 19255, Springfield, IL 62794-9255	217-785-7444 866-321-7625 (TDD/TTY)	srs.illinois.gov
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
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
CMS Bureau of Benefits Group Insurance	PO Box 19208, Springfield, IL 62794-9208	800-442-1300 800-526-0844 (TDD/TTY)	benefitschoice.il.gov

Federally Required Notices

Notice of Creditable Coverage (HMO, OAP, and QCHP ONLY)

Prescription Drug information for State of Illinois Medicare-eligible Plan Participants

This Notice confirms that the State Employees Group Insurance Program (SEGIP) has determined that the prescription drug coverage it provides for its HMO, OAP, and QCHP plans is Creditable Coverage. This means that the prescription coverage offered through SEGIP 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 SEGIP 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 SEGIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after your SEGIP coverage ends.

If you keep your existing group coverage through SEGIP, 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).

Notice of Non-Creditable Coverage (CDHP ONLY)

Prescription Drug information for State of Illinois Medicare-eligible Plan Participants

This will serve as notice that the State Employees Group Insurance Program (SEGIP) has determined that the prescription drug coverage it provides for the Consumer Driven Health Plan (CDHP) is Non-Creditable Coverage as of July 1, 2025. This is due to provisions of the Federal Inflation Reduction Act (IRA) that went into effect in 2025, reducing the True Out of Pocket costs (TrOOP) on standard Medicare prescription drug coverage (Medicare Part D). This means that the CDHP plan likely does not cover as much of the cost of prescription drugs as a standard Medicare Part D plan.

As a result, you may be penalized if you elect the CDHP (high deductible) plan and later decide to enroll in a Medicare prescription drug plan. To avoid any future penalties, please consider enrolling in one of the creditable coverage plans listed above.

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 State 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, 2025. 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).

Benefit Choice Fairs

CMS sponsored Benefit Choice Open Enrollment Member Fairs are scheduled from **9:00 am to 4:00 pm**, with two identical presentations given at **11:00 am and 2:00 pm**. Events are open to all active and retired members not enrolled in the Medicare Advantage Prescription Drug (MAPD) plan. CMS representatives, as well as various benefit vendors, will be present during the in-person fairs to answer questions.

Date		Agency/ Location	Address
Thursday	May 1, 2025	Virtual Recording	https://cms.illinois.gov/benefits/benefit-choice-fairs.html
Friday	May 2, 2025	Stratton - Springfield	401 S. Spring St, Stratton Building, 4th Floor, Room 413, Springfield, 62701
Monday	May 5, 2025	GSU - University Park	1 University Parkway, Engbretson Hall & Hall of Honors, University Park, 60484
Tuesday	May 6, 2025	Downtown - Chicago	555 W. Monroe, Lincoln & Chicago Conference Rooms, 4th Floor, Chicago, 60661
Wednesday	May 7, 2025	CSU - Chicago	9501 South King Drive, Gwendolyn Brooks Library, 4th Floor, Rooms 410 & 415, Chicago, 60628
Thursday	May 8, 2025	NEIU - Chicago	5500 N. St. Louis Ave, Rooms SU003 & SU214, Chicago, 60625
Friday	May 9, 2025	NIU - Dekalb	340 Carroll Ave, Holmes Student Center, Regency Room & Carl Sandburg Auditorium, Dekalb, 60115
Monday	May 12, 2025	ISU - Normal	100 N. University St, Bone Student Center, Prairie Room, Normal, 61790
Tuesday	May 13, 2025	DHS - Elgin	750 S. State St, Rehabilitation Building, Rehab Auditorium, Elgin 60123
Wednesday	May 14, 2025	Downtown - Chicago	160 N. LaSalle St, 5th Floor Auditorium & Room N505, Chicago, 60601
Thursday	May 15, 2025	UIC - Chicago	1200 West Harrison St, Student Services Building Rooms A, B & C, Chicago, 60607
Friday	May 16, 2025	WIU - Moline	3300 River Drive, W Riverfront Hall, Goldfarb Grand Atrium, Moline, 61265
Monday	May 19, 2025	IDOT- Collinsville	1102 Eastport Plaza Drive, IDOT District 8, Class Room, Lunch Room and Foyer, Collinsville, 62234
Tuesday	May 20, 2025	SIU - Carbondale	1255 Lincoln Drive, Student Center, Ballroom B & Corker Lounge, Carbondale, 62901
Wednesday	May 21, 2025	EIU - Charleston	600 Lincoln Ave, Martin Luther King Jr. University Union, Grand Ballroom & Room 1895, Charleston, 61920
Wednesday	May 21, 2025	Virtual Recording	https://cms.illinois.gov/benefits/benefit-choice-fairs.html
Thursday	May 22, 2025	UIUC - Champaign	iHotel 1900 S. First St, Quad & Technology Rooms, Champaign, 61820
Friday	May 23, 2025	UIS - Springfield	2251 Richard Wright Dr, Student Union, Rooms 224, 224 & 226, Springfield, 62703
Monday	May 26, 2025	Memorial Day	CLOSED. No Member Fairs Scheduled.
Tuesday	May 27, 2025	IDOT - Springfield	2300 S. Dirksen Parkway, Auditorium, Springfield, 62764
Wednesday	May 28, 2025	DVA - Quincy	1707 N. 12th Street, Lippincott Building, Quincy, 62301
Thursday	May 29, 2025	IDOT - Peoria	401 Main St, Becker Building, 6th Floor, Peoria, 61602
Friday	May 30, 2025	WIU - Macomb	911 W. Murray St, Multicultural Center, Macomb, 61455

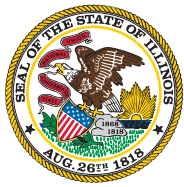
The two virtual recordings will begin at 11:00 am.
To join the virtual recordings for the Member Fairs, please scan the QR code:
or use <https://cms.illinois.gov/benefits/benefit-choice-fairs.html>

**SCAN
ME!**



Notes

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



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Bureau of Benefits
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