benefit choice

Open Enrollment Period:
May 1, 2026 – June 1, 2026

Coverage Changes Effective:
July 1, 2026

Benefit Choice Member Fair Locations

Date		Agency/Location	Address
Monday	4-May	CMS Regional Complex	4800 Wabash Ave, 1st Floor Training Room & Cafeteria, Springfield, 62711
Tuesday	5-May	Illinois State University	100 N. University St., Bone Student Center & Prairie Room, Normal, 61761
Wednesday	6-May	University of Illinois Urbana-Champaign	iHotel 1900 S. First St, Quad/Alma Mater Rooms & Technology Room, Champaign, 61820
Thursday	7-May	Dept of Veterans Affairs	1707 N. 12th Street, Lippincott Building, Quincy, 62301
Friday	8-May	Illinois Dept of Transportation	1102 Eastport Plaza Drive, IDOT District 8, Classroom, Breakroom & Foyer, Collinsville, 62234
Monday	11-May	Western Illinois University - Macomb	1 University Circle, University Union - Heritage Room, Macomb, 61455
Tuesday	12-May	Western Illinois University - Moline	3300 River Drive, W. Riverfront Hall, Goldfarb Grand Atrium, Moline, 61265
Wednesday	13-May	Northern Illinois University	340 Carroll Ave, Holmes Student Center, Regency Room & Sandburg Auditorium, DeKalb, 60115
Thursday	14-May	DHS - Elgin Mental Health Center	750 S. State St., Assembly Hall, Elgin, 60123
Friday	15-May	SIU - School of Medicine	801 N. Rutledge, 2nd Floor & South Auditorium, Springfield, 62702
Monday	18-May	Northeastern Illinois University	5500 N. St. Louis Ave, Rooms SU103 & SU115, Chicago, 60625
Tuesday	19-May	Chicago - Downtown	555 W. Monroe Street, 4th Floor Lincoln & Springfield Conference Rooms, Chicago, 60661
Wednesday	20-May	University of Illinois - Chicago	710 S. Halsted, 6th Floor, Student Center East Tower, Rooms 603/605 & 613, Chicago, 60607
Thursday	21-May	Chicago State University	9501 S. King Drive, Gwendolyn Brooks Library, 4th Floor, Rooms 410 & 415, Chicago, 60628
Friday	22-May	Governors State University	1 University Parkway, Engbretson Hall & Hall of Honors, University Park, 60484
Monday	25-May	Memorial Day - CLOSED	
Tuesday	26-May	Southern Illinois University - Carbondale	1255 Lincoln Drive, Student Center 2nd Floor, Ballroom B & Corker Lounge, Carbondale, 62901
Wednesday	27-May	Eastern Illinois University	600 Lincoln Ave, Martin Luther King Jr. University Union, Grand Ballroom & Room 1895, Charleston, 61920
Thursday	28-May	Illinois Dept of Transportation	2300 S. Dirksen Parkway, Auditorium, Springfield, 62764

Employee Responsibilities

The following is a list of your responsibilities as a participant in the Group Insurance Program:

- Notify MyBenefits.illinois.gov, or by calling the MyBenefits Service Center (toll-free) 1-844-251-1777 immediately when life changes occur that may impact your eligibility or your dependent(s)' eligibility. If you are unsure if an event could affect your Group Insurance coverage, we strongly urge you to contact your Group Insurance Representative and they will guide you.

  Life changing events include:

  - Birth/adoption of a child
  - Marriage or Civil Union Partnership
  - Divorce, legal separation, annulment or Dissolution of Civil Union Partnership
  - Death of a spouse or other dependent
  - Change in your, your spouse's or your dependent's employment status that affects eligibility under the plan
  - Your dependent is provided group insurance through their employer
  - Your dependent no longer meets the group insurance eligibility criteria
  - Your dependent becomes ineligible for other coverage
  - You gain or lose custody of a dependent (must be court ordered)
  - Your Public Aid or Medicare status changes.

  NOTE: When adding or dropping a dependent, proper documentation must accompany your request.

- Employees must notify your Group Insurance Representative immediately when you go on and return from a Leave of Absence.

- Notify your Group Insurance Representative immediately when you change your home address. However, if a dependent changes their address, the member must call MyBenefits Service Center (toll-free) 844-251-1777 immediately.

- Notify the Medicare COB at 217-782-7007 immediately if you experience a change in your Medicare status, or if another insurance plan becomes primary payer.

- Monitor your payroll deductions and coverage elections to verify accuracy. Notify the MyBenefits Service Center by calling (toll-free) 844-251-1777 immediately if the deductions or elections are not correct. If not, you may not be eligible for a full refund.

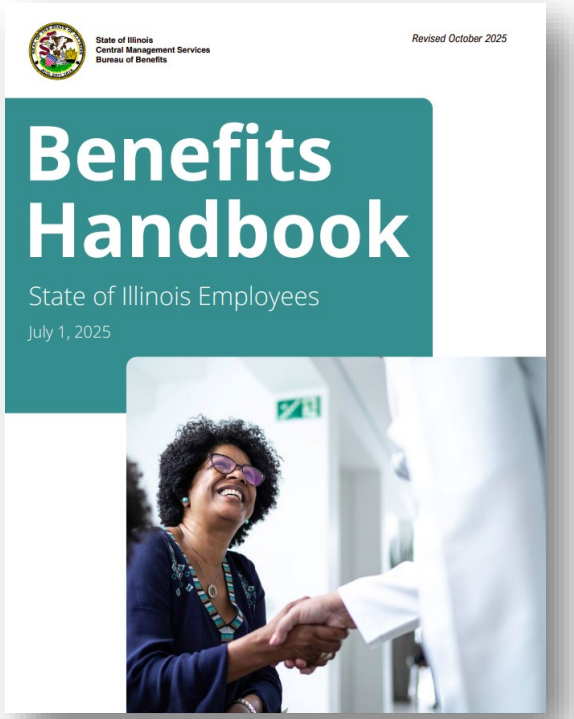
For further information concerning your benefits under the Group Insurance Program refer to the latest version of the State of Illinois Benefits Handbook (MyBenefits.illinois.gov) or call the MyBenefits Service Center (toll-free) 844-251-1777.

Updated 03.24.2026

Members experiencing a qualifying change in status have 60 days from the date of the event to change certain benefit elections.

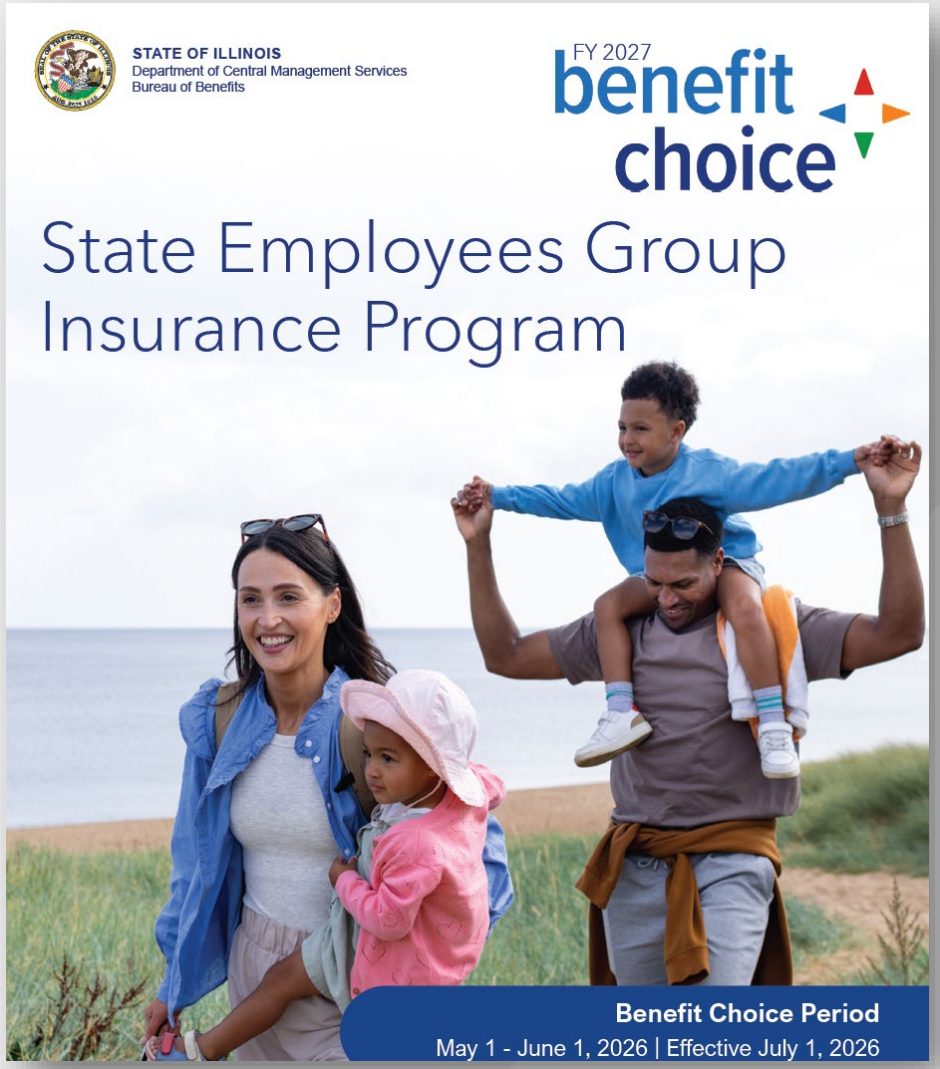
Members must submit required documentation to MyBenefits.Illinois.gov within the designated time limits.

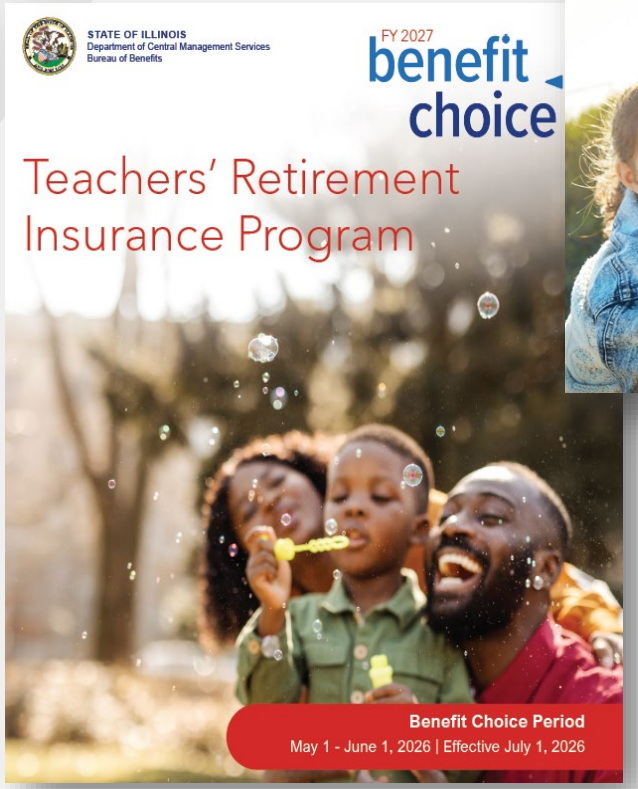
- **Initial Enrollment Period** → Within 30 days of the event
- **Annual Benefit Choice Open Enrollment Period** → Within 10 days of the Benefit Choice Period ending
- **Qualifying Change in Status** → Within 60 days of the event

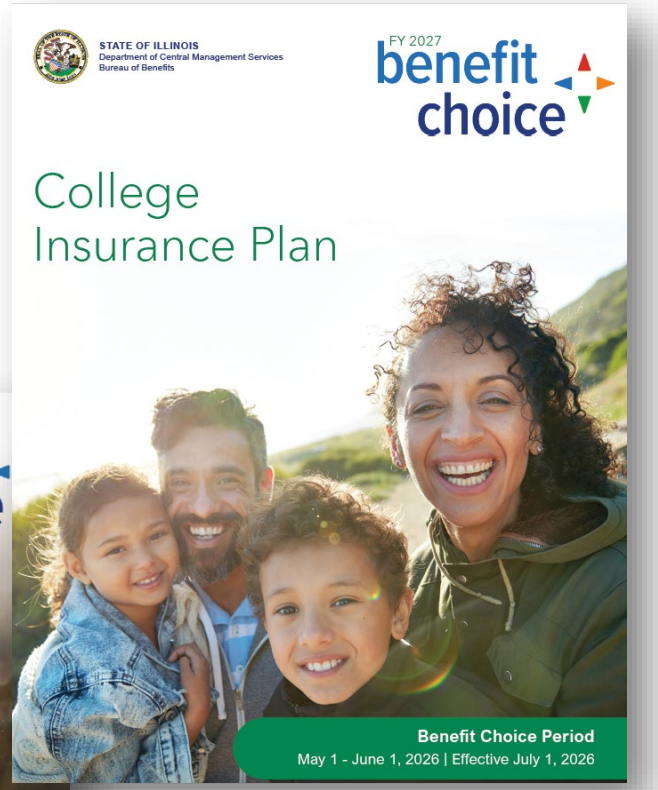


****Refer to the CMS Benefits Handbook-Qualifying Changes in Status Matrix.***

- **Electronic versions are available at mybenefits.illinois.gov**

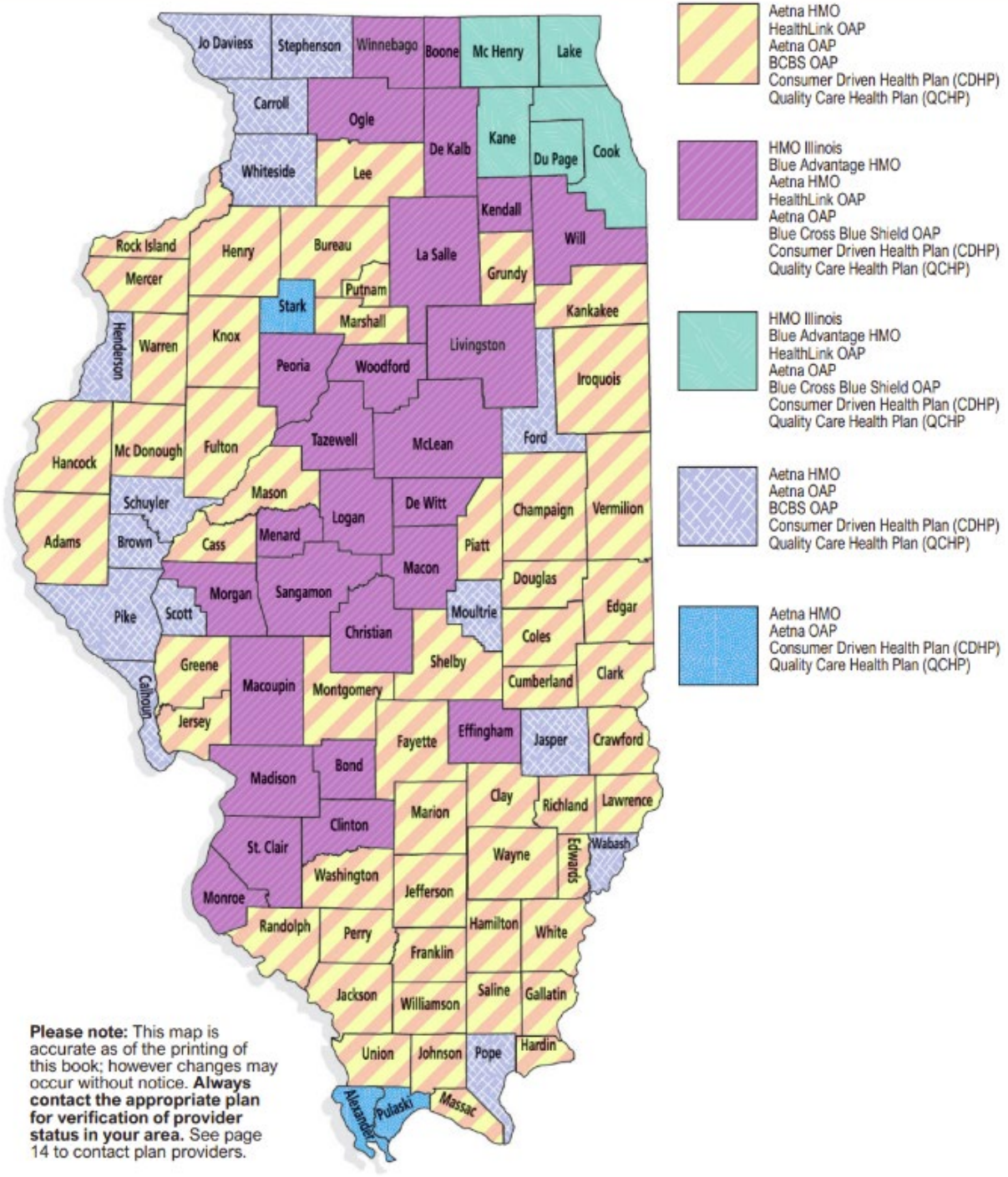






Health Plan Administrators Available By County

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



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 14 to contact plan providers.

Health Plan Administrators

HMO

- Aetna HMO
- BlueAdvantage HMO
- HMO Illinois

OAP

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

PPO

- Consumer Driven Health Plan (CDHP) - Aetna PPO
- Quality Care Health Plan (QCHP) - Aetna PPO

HMO, OAP & PPO Explained

Health Maintenance Organization (HMO) options – depend on work/residential county. HMOs require use of their plan provider network and to select primary care physician (PCP), there is no out of network service, coverage is only available within the state of Illinois, except for emergency services. HMOs require a referral from your PCP for specialty care. HMOs have copayments, which is a set dollar amount, for medical services, rather than deductibles and coinsurance.

Open Access Plan (OAP) options – offers the convenience of the above noted HMO benefits with Tier I network of physicians, without the requirement of referrals. But also has the flexibility to use the expanded Tier II PPO network of physicians that includes deductibles, plan year out of pocket maximums and coinsurance, which is the percentage that the member is responsible for after the deductible has been met, it's a form of cost-sharing between the insurance company and the member. And the option to use the Tier III out of network physicians with higher deductibles, no maximum out of pocket expenses and greater percentage coinsurance expenses.

Preferred Provider Organization (PPO) options – a larger network of physicians and hospitals, coverage in and out the state of Illinois, has both in and out of network of physicians, with enhanced benefits for utilizing in-network providers resulting in lower out of pocket costs. These plans have individual and family plan year deductibles, maximum out of pocket limits and higher percentage of coinsurance expenses.

The Consumer Driven Health Plan (CDHP) – is only available to active State members (not available for retirees). The plan is a PPO as noted above; however, has a higher deductible but a slightly lower percentage of medical coinsurance expenses. Prescription drugs under this plan are a coinsurance instead of a copayment. State employees have the option of enrolling in the companion Health Savings Account (HSA), in which the State will contribute 1/3 of the deductible to the HSA. Members also have the option of contributing a pretax amount to be deposited into the HSA.

State Members Monthly Health Plan Contributions

- Member Rates are based on your March 1st Annual Salary.
- Member Rates increased by $8.
- **Salary Band ranges have changed!**

Employee Annual Salary	Aetna HMO	Blue Advantage	HMO Illinois	Aetna OAP	BCBSIL OAP *	HealthLink OAP	CDHP **	QCHP ***
$34,600 & below	$146	$120	$124	$140	$140	$154	$121	$160
$34,601 - $52,300	$165	$139	$143	$159	$159	$173	$140	$179
$52,301 - $69,600	$184	$158	$162	$178	$178	$192	$159	$197
$69,601 - $87,000	$202	$176	$180	$196	$196	$210	$177	$216
$87,001 - $114,700	$221	$195	$199	$215	$215	$229	$196	$235
$114,701 - $143,300	$275	$249	$253	$269	$269	$283	$250	$289
$143,301 - and over	$308	$282	$286	$302	$302	$316	$283	$322

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State Members
Dependent Monthly Health Plan Contributions

Number of Dependents	Aetna HMO	Blue Advantage	HMO Illinois	Aetna OAP	BCBSIL OAP *	HealthLink OAP	CDHP **	QCHP ***
1 Dependent	$209	$172	$176	$200	$200	$218	$183	$305
2+ Dependents	$254	$208	$215	$245	$245	$271	$227	$343
1 Medicare A & B Primary Dependent	$186	$151	$155	$177	$177	$194	$160	$198
2+ Medicare A & B Primary Dependents	$228	$186	$192	$219	$219	$241	$201	$259

Dependent Rates have increased by $4, are in addition to Member Rates; and are based on the Number of Dependents covered, Plan Enrollment and Medicare Primacy.

Co-payments

- HMO
  - Plan year Out of Pocket Max:
    - $3,000 Individual
    - $6,000 Family
  - In-Network
    - Preventive Care 100%
    - Physician Office Visit $30
    - Specialist & Home Health Care Visit $40
    - ER Services $275
    - Inpatient Services $525
    - Outpatient Surgery $400
  - Out-of-Network
    - Nothing is covered except ER Services $275

Coinsurance & Deductibles

- OAP
  - Tier I
    - Same as HMO In-Network
  - Tier II $325 Plan Year Deductible/Enrollee
    - Preventive Care 100%
    - Physician & Specialist 90%
    - ER Services $275
    - Inpatient Services 90% after $575 copay
    - Outpatient Surgery 90% after $400 copay
  - Tier III $425 Plan Year Deductible/Enrollee
    - Preventive Care not covered
    - Physician & Specialist 60%
    - ER Services $275
    - Inpatient Services 60% after $675 copay
    - Outpatient Surgery 60% after $400 copay

Coinsurance & Deductibles

- PPO-QCHP
  - Plan Year Deductibles
    - Vary based on Salary/Individual/Family
  - In-Network – Deductible Applies
    - Preventive Care 100%
    - Physician & Specialist visits 85%
    - ER Services $450
    - Inpatient Services 85% after $300
    - Outpatient Surgery 85%
  - Out-of-Network – Deductible Applies
    - Preventive Care 60%
    - Physician & Specialist 60%
    - ER Services $450
    - Inpatient Services 60% after $900
    - Outpatient Surgery 60%

Coinsurance & Deductibles

- PPO-CDHP
  - Plan Year Deductibles
    - $1,700 Individual
    - $3,400 Family
  - In-Network – Deductible Applies
    - Preventive Care 100%
    - Preventive Services 90%
    - Physician & Specialist visits 90%
    - ER Services 90%
    - Inpatient Services 90%
    - Outpatient Surgery 90%
  - Out-of-Network – Deductible Applies
    - Preventive Care/Services 65%
    - Physician & Specialist 65%
    - ER Services 90%
    - Inpatient Services 65%
    - Outpatient Surgery 65%

Percentages listed represent how much is covered by the plan

Prescription Drug Coverage

- **HMO (not CVS)**

Prescription Drugs				
Plan Year Pharmacy Deductible – $175 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.

- **OAP**

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	$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.

- **PPO-QCHP**

Prescription Drugs			
Plan Year Pharmacy Deductible – $200 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.

- **PPO-CDHP**

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.

CVS caremark®

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Flexible Spending Accounts

MCAP

The FY27 maximum contribution limit increased to $3,400.
New rollover for unused funds will be capped at $680 for FY27.
Rollover amount is $660, for those currently enrolled in FY26 MCAP.

Reminder

Participants who do not re-enroll in MCAP for the new plan year will forfeit any amount eligible for rollover.

DCAP

The FY27 maximum contribution amount increased to $7,500.
All unused funds at the end of the plan year will be forfeited.

Optum Financial®

Health Savings Account (HSA) enrollment options:

- The **employer** contribution and/or
- The **employee** contribution.

If you were previously enrolled in CDHP/HSA and elected the **employer** contribution, that election will automatically be re-enrolled each year.

However, you must make the **employee** contribution elections every year.

Health Savings Accounts (HSA) Companion to CDHP Enrollment ONLY

Under Age 55

	Individual	Family
Employer Contribution =	$566.67	$1,133.34
Employee Contribution =	$3,833.33	$7,616.66
Max IRS Allowed Contribution =	$4,400	$8,750

Optum Financial®

Aged 55 and older

	Individual	Family
Employer Contribution =	$566.67	$1,133.34
Employee Contribution =	$4,833.33	$8,616.66
Max IRS Allowed Contribution =	$5,400	$9,750

CENTRAL MANAGEMENT SERVICES CMS ILLINOIS

Years of Service at Retirement (1)	Contribution Percentage	QCHP Coverage		HMO Coverage	
		Medicare	Non-Medicare	Medicare	Non-Medicare
		Total Rate = *$715.44*	Total Rate = *$1,524.45*	Total Rate = *$857.12*	Total Rate = *$1,573.57*
0	100%	$ 715.44	$ 1,524.45	$ 857.12	$ 1,573.57
1	95%	$ 679.66	$ 1,448.22	$ 814.26	$ 1,494.89
2	90%	$ 643.89	$ 1,372.00	$ 771.40	$ 1,416.21
3	85%	$ 608.12	$ 1,295.78	$ 728.55	$ 1,337.53
4	80%	$ 572.35	$ 1,219.56	$ 685.69	$ 1,258.85
5	75%	$ 536.58	$ 1,143.33	$ 642.84	$ 1,180.17
6	70%	$ 500.80	$ 1,067.11	$ 599.98	$ 1,101.49
7	65%	$ 465.03	$ 990.89	$ 557.12	$ 1,022.82
8	60%	$ 429.26	$ 914.67	$ 514.27	$ 944.14
9	55%	$ 393.49	$ 838.44	$ 471.41	$ 865.46
10	50%	$ 357.72	$ 762.22	$ 428.56	$ 786.78
11	45%	$ 321.94	$ 686.00	$ 385.70	$ 708.10
12	40%	$ 286.17	$ 609.78	$ 342.84	$ 629.42
13	35%	$ 250.40	$ 533.55	$ 299.99	$ 550.74
14	30%	$ 214.63	$ 457.33	$ 257.13	$ 472.07
15	25%	$ 178.86	$ 381.11	$ 214.28	$ 393.39
16	20%	$ 143.08	$ 304.89	$ 171.42	$ 314.71
17	15%	$ 107.31	$ 228.66	$ 128.56	$ 236.03
18	10%	$ 71.54	$ 152.44	$ 85.71	$ 157.35
19	5%	$ 35.77	$ 76.22	$ 42.85	$ 78.67
20+	0%	$ -	$ -	$ -	$ -

(1) The rates shown for less than 8 years of service apply to survivors.

Health Plan Rates for Retirees with under 20 years of service.

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.

- Vision coverage is still included with the Health Plan enrollment.
- EyeMed offers additional coverage for Progressive Lenses, Premiums Anti-Reflective Coating, and coverage for Photochromic and Polarized lenses. As well as Diabetic Care Services.
- For more information visit https://member.eyemedvisioncare.com/stil/en-us

DIABETIC CARE SERVICE	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
For Type 1 or Type 2 Diabetes with Diabetic Retinopathy		
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**		

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

Member Monthly Quality Care Dental Plan (QCDP) Contributions**		
Member Only	**Member + 1 Dependent**	**Member + 2 or More Dependents**
$17.00	$29.00	$31.50

People Eligible	Treatment	Coverage Level	Frequency per Benefit Year
Individuals with: • Diabetes • Kidney Failure/Dialysis Treatment • High-Risk Cardiac Conditions*	Prophylaxis (General Cleaning) and Periodontal Maintenance	Same Percent as the Group/Individual Contracted Benefit Level	4 Times Total in any Combination
Individuals with: • Periodontal Disease • Suppressed Immune Systems** • Cancer-Related Chemotherapy and/or Radiation Treatments • Special Needs***	Prophylaxis (General Cleaning) and Periodontal Maintenance Topical Fluoride Treatment (No Age Limits)	Same Percent as the Group/Individual Contracted Benefit Level Same percent as the Group/Individual Contracted Benefit Level	4 Times Total in any Combination Frequency Determined by Group/Individual Contract
Pregnant Women	Prophylaxis (General Cleaning) and Periodontal Maintenance	Same Percent as the Group/Individual Contracted Benefit Level	3 Times Total in any Combination

- Dental Only coverage is an option, and dependent coverage must mirror that coverage.
- Delta Dental of Illinois has enhanced coverage for individuals who have specific health conditions that can be positively affected by additional oral health care.
- For more information on this program visit www.deltadentalil.com

MetLife

- There have been no premium changes for life coverage.
- Basic Life Insurance coverage is provided at no cost to all active employees, retirees, and annuitants.
- **Member Optional Life coverage** is provided at a cost.
  - 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.
- 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 SOH is not needed to add Child Life coverage or AD&D.
- Don't forget to elect beneficiaries at https://www.metlife.com/info/stateofillinois/

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

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

Spouse Life Monthly Rates	
Spouse Life $10,000 Coverage (Members, retirees, and annuitants under aged 60)	$5.70
Spouse Life $5,000 Coverage (Retirees and annuitants aged 60 and older)	$2.85

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

State of Illinois Deferred Compensation Plan

Mandatory Roth Catch-Up Contributions

- Beginning in 2026, participants that earned over $150,000 in Social Security wages during the previous calendar year must make age-based catch-up contributions on a Roth basis.
  - Participants that do not contribute to Social Security are exempt.
  - Only impacts age-based catch-up contributions.
    - Age-50 catch-up ($8,000 in 2026).
    - Age 60-63 catch-up ($11,250 in 2026).
    - Special Catch-Up is exempt.
  - Regular contributions may still be made on a pre-tax basis ($24,500 in 2026).
  - Social Security wages are provided to CMS by the Comptroller's Office (Box 3 of the W-2).

Deferred Compensation Plan Changes

New Benefit Service for SEGIP, CIP & TRIP

Health Advocate℠

Effective May 1, 2026, a new service is available for you and your covered dependents.

Health Advocate is here to help you and your covered dependents with any health or well-being issues. You get access to experts who will do the work to ensure that you get the right information and assistance at the right time. What can they assist with?

- ✔ **Finding** the right in-network providers
- ✔ **Clarifying** tests and treatments
- ✔ **Resolving** claims and billing issues
- ✔ **Answering** benefit questions
- ✔ **Scheduling** appointments and transfer medical records
- ✔ **Exploring** treatments and get second options

Your NEW Health Advocate benefit offers:

- **Personalized support** for a variety of health and well-being issues
- **Confidential compassionate help** in any language
- **Unlimited access** for you, your spouse/partner and dependents
- **Independent support that works for you** and not affiliated with any insurance company or provider
- **Provided** at no cost to you!

Expert help, delivered with heart

Who can use the program?

- Actives
- Retirees
- Recently Terminated (for those actively participating)
- Survivors
- COBRA eligible members

- Plus, spouse/partner & dependents

Important Notes About Health Advocate's Service

Health Advocate does not replace health insurance

Health Advocate does not provide medical care or recommended treatment

Private and confidential

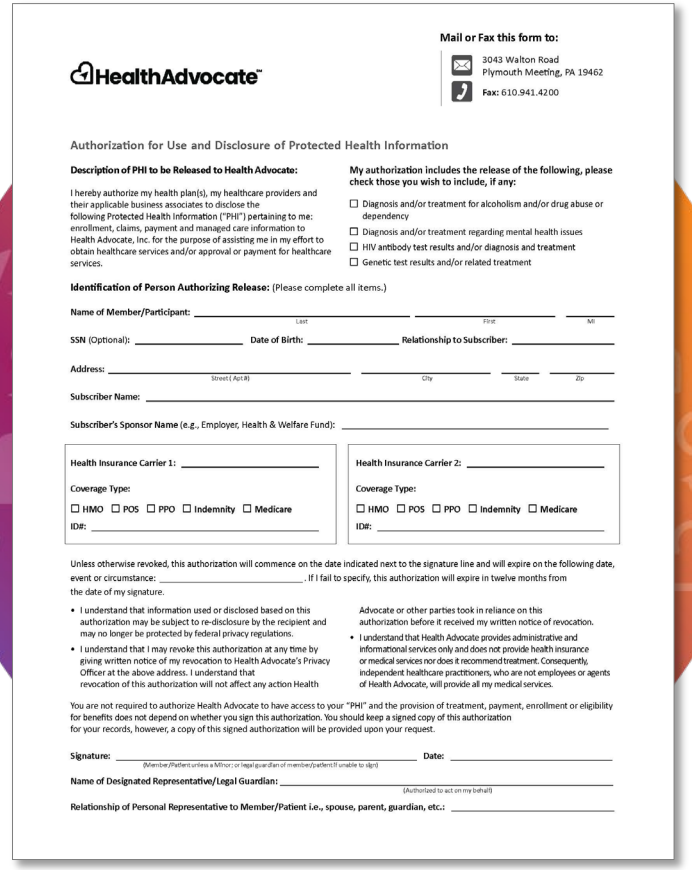
Your privacy is protected

All health information is kept strictly confidential

Health Advocate fully comply with the federal Health Insurance Portability and Accountability Act (HIPAA)

Medical Authorization Release Form

- **Authorizes Health Advocate to interact with doctors,** other providers and insurance companies on your behalf.
- **One-page form can be downloaded from member website or app**, sent via DocuSign, emailed, mailed or faxed to you to complete and return.
- **Secure electronic signature** service also available.
- **Ensures complete confidentiality** and privacy.



HealthAdvocate℠

Mail or Fax this form to:

3043 Walton Road
Plymouth Meeting, PA 19462
Fax: 610.941.4200

Authorization for Use and Disclosure of Protected Health Information

Description of PHI to be Released to Health Advocate:

I hereby authorize my health plan(s), my healthcare providers and their applicable business associates to disclose the following Protected Health Information ("PHI") pertaining to me: enrollment, claims, payment and managed care information to Health Advocate, Inc. for the purpose of assisting me in my effort to obtain healthcare services and/or approval or payment for healthcare services.

My authorization includes the release of the following, please check those you wish to include, if any:

- ☐ Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- ☐ Diagnosis and/or treatment regarding mental health issues
- ☐ HIV antibody test results and/or diagnosis and treatment
- ☐ Genetic test results and/or related treatment

Identification of Person Authorizing Release: (Please complete all items.)

Name of Member/Participant: _____ (Last) _____ (First) _____ (MI)

SSN (Optional): _____ **Date of Birth:** _____ **Relationship to Subscriber:** _____

Address: _____ (Street (Apt #)) _____ (City) _____ (State) _____ (Zip)

Subscriber Name: _____

Subscriber's Sponsor Name (e.g., Employer, Health & Welfare Fund): _____

Health Insurance Carrier 1: _____

Coverage Type:

☐ HMO ☐ POS ☐ PPO ☐ Indemnity ☐ Medicare

ID#: _____

Health Insurance Carrier 2: _____

Coverage Type:

☐ HMO ☐ POS ☐ PPO ☐ Indemnity ☐ Medicare

ID#: _____

Unless otherwise revoked, this authorization will commence on the date indicated next to the signature line and will expire on the following date, event or circumstance: _____. If I fail to specify, this authorization will expire in twelve months from the date of my signature.

- I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization at any time by giving written notice of my revocation to Health Advocate's Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action Health Advocate or other parties took in reliance on this authorization before it received my written notice of revocation.
- I understand that Health Advocate provides administrative and informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent healthcare practitioners, who are not employees or agents of Health Advocate, will provide all my medical services.

You are not required to authorize Health Advocate to have access to your "PHI" and the provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.

Signature: _____ (Member/Patient unless a Minor; or legal guardian of member/patient if unable to sign) **Date:** _____

Name of Designated Representative/Legal Guardian: _____ (Authorized to act on my behalf)

Relationship of Personal Representative to Member/Patient i.e., spouse, parent, guardian, etc.: _____

How to Connect with Health Advocate

Call 844.251.1777: Follow prompts to connect directly to **Health Advocate or** ask a **TELUS Health Client Service Team** member for a transfer.

Online access: Log in to**MyBenefits.Illinois.gov** to chat or message a Health Advocate directly.

Dedicated support: Once connected, a Health Advocate is assigned to your case.

Issue resolution: Your advocate works on your behalf until your issue is resolved.

Making healthcare easier for you

- **Explain coverage and benefits**
- **Help resolve billing** and insurance claim issues
- **Negotiate** bills when appropriate
- **Explain Medicare** and how it works
- **Find doctors** and help schedule appointments
- **Transfer medical records** between providers
- **Help you get to all your benefits**
- **Help reduce prescription and healthcare costs**

Expert clinical support

- **Answer questions** on diagnoses, treatments, and tests
- **Prep for doctor visits;** review results and next steps
- **Compare cost** and quality of care
- **Coordinate care** with providers
- **Support medical decisions** and coordinate second opinions
- **Facilitate pre-authorizations**

How to reach Health Advocate

Phone:
844.251.1777

Email:
answers@HealthAdvocate.com

Website:
MyBenefits.Illinois.gov

Registration code:
STATEOFIL

Hours of Operation: Monday-Friday from 8am - 6pm CST
After hours, weekends and State of IL holidays, members encouraged to leave a message or call back during standard business hours.

Total Wellbeing

A New Addition To BeWell!

powered by TELUS® Health

be well ILLINOIS

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.

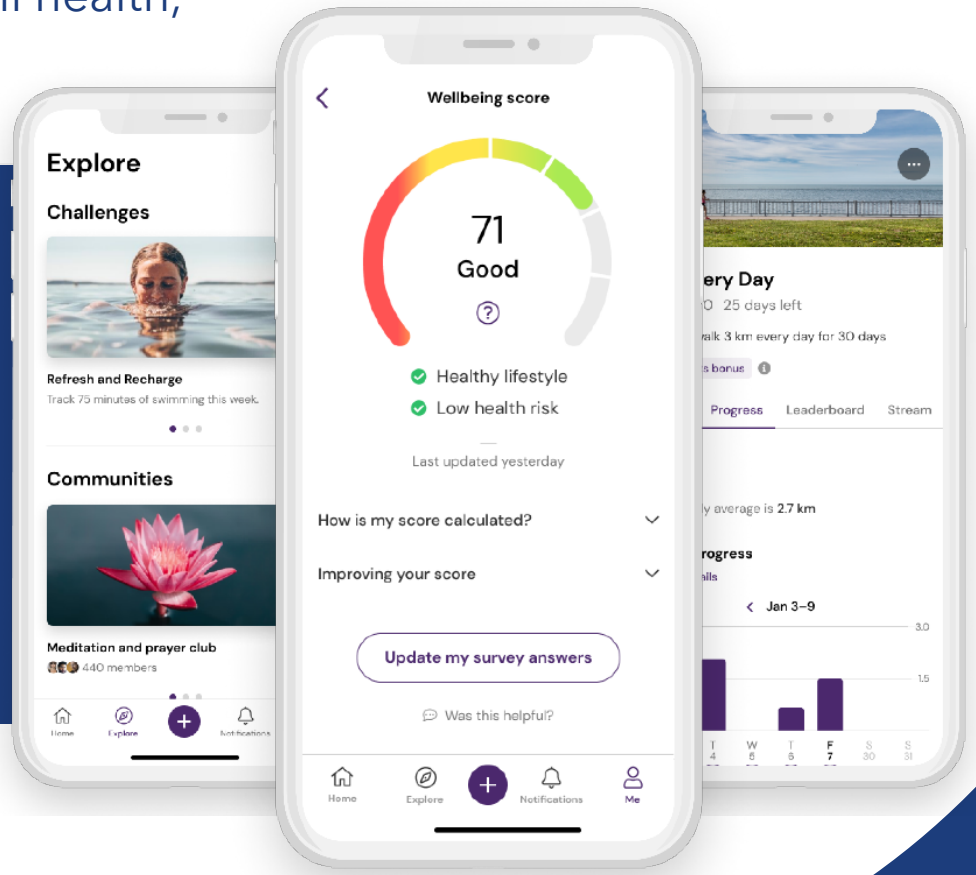
- Visit us at www.Illinois.gov/BeWell
- Follow us on Facebook at https://www.facebook.com/BeWellIllinois
- Or email us at BeWell@illinois.gov

BeWell Total Wellbeing

Coming soon!

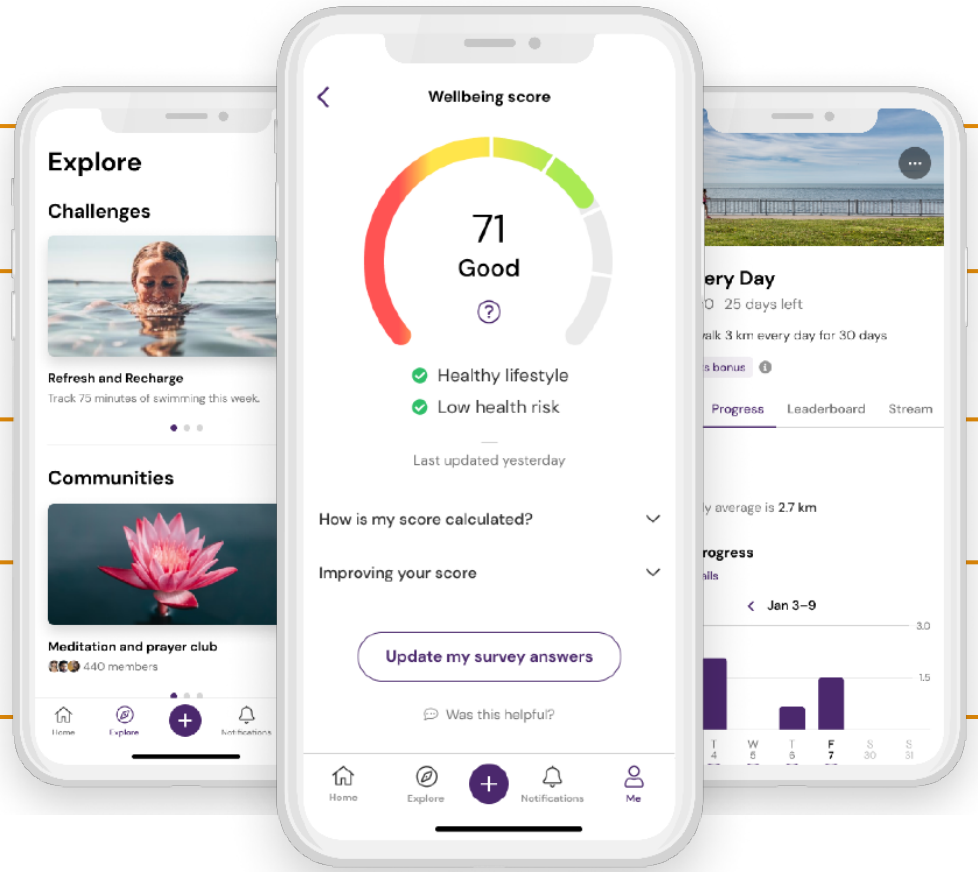
TELUS Health Wellbeing is a digital health platform designed to help employees embrace wellbeing and improve their overall health, available on mobile and desktop.

- Powered by machine learning.
- Real-time insights and analytics.
- Helping organizations build a healthy, productive and engaged workforce.



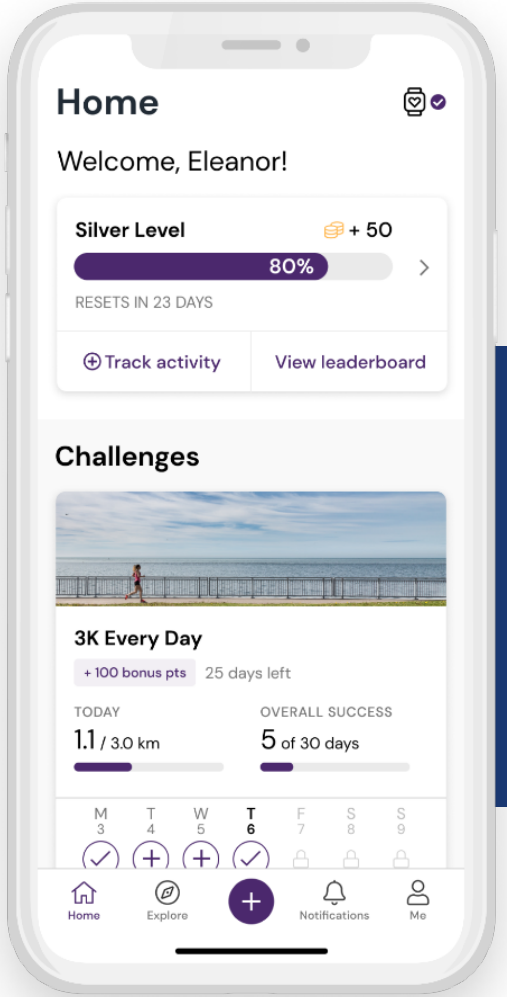
Platform Features

- Health Risk Assessments
- Rewards
- Content library
- Activity tracking
- Insights & analytics
- Gamified challenges



- Wearable integrations
- Smart goals
- Leaderboards
- Events
- Social streams
- Communities

Challenges

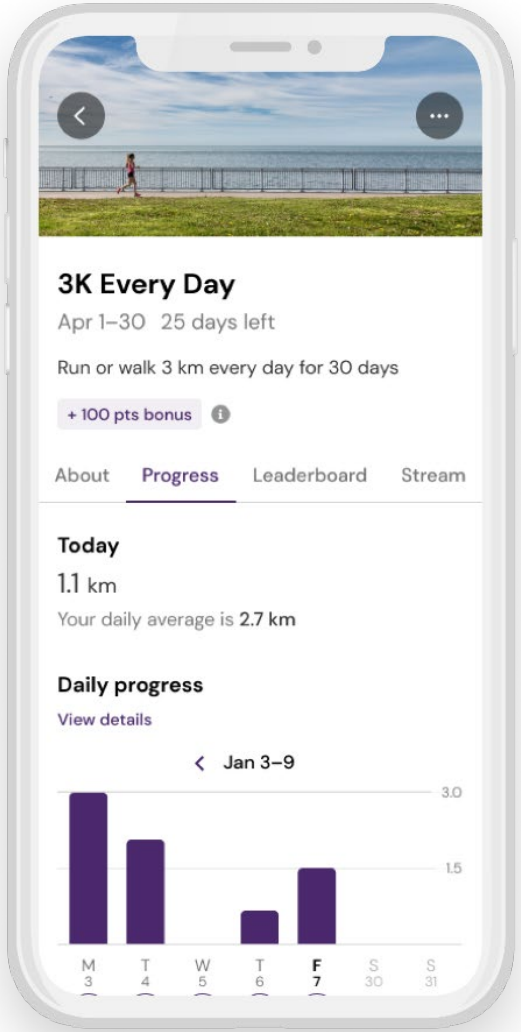


Designed using cognitive behavioral science, our holistic challenges create opportunities for users to compete and reach **new personal bests** for improved health and wellbeing.

- Drive engagement
- Build company culture
- Promote positive behavior modelling

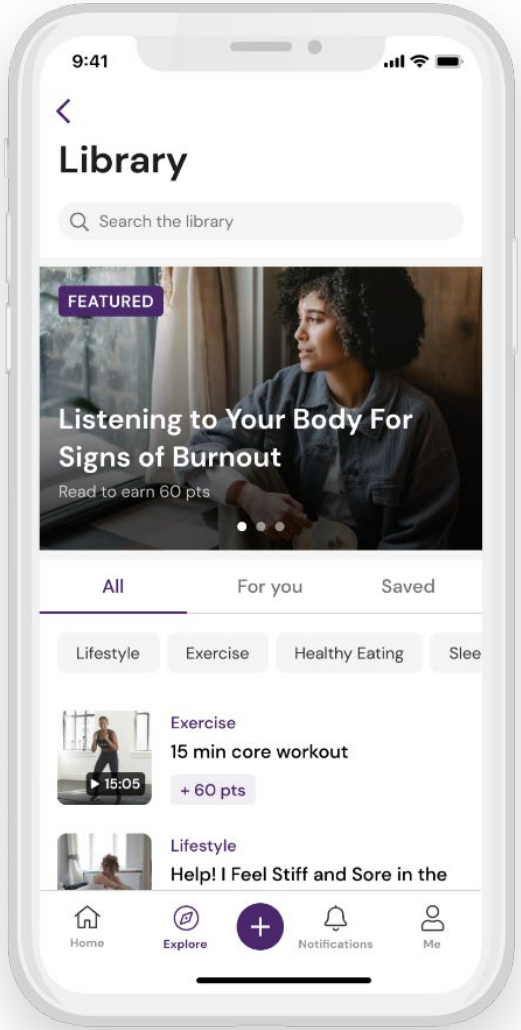
Goals

Our personalized **smart mode** and **restart goals** help engage and inspire employees with actionable science-based recommendations.



Designed to help you move, eat and feel better to create lasting positive behaviors.

Content Library



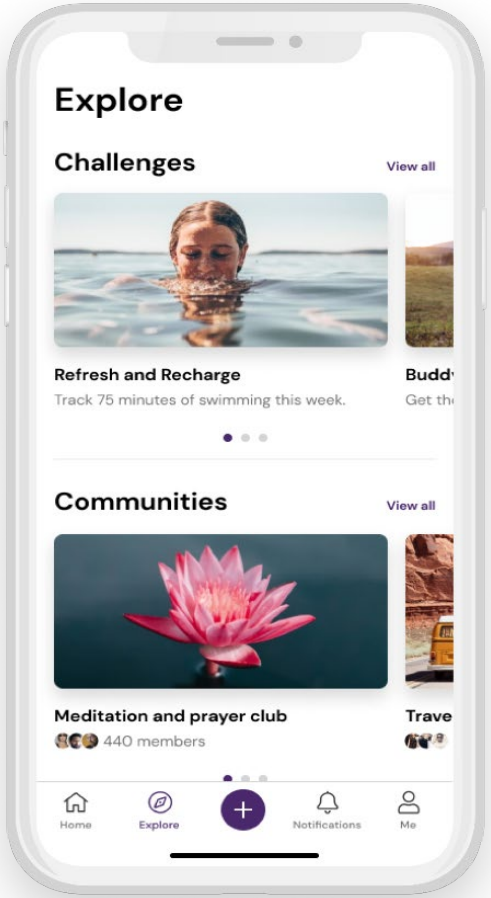
Unlimited access to informative and engaging videos, articles, and more to support employees with content offerings **personalized** to their interests.

- **Personalized content recommendations** based on our machine learning model.
- **New content** added regularly.
- **Can be customized** with your organization's unique content.

Communities & Events

Communities

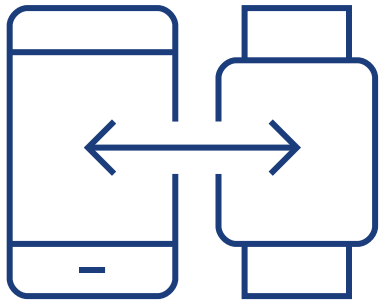
Employees can easily connect over shared health interests, lend support and create meaningful social interactions with their colleagues.



Events

Quickly and easily join events, community or personal events to engage with your team members with virtual or in-person events.

Wearable & Device Integrations



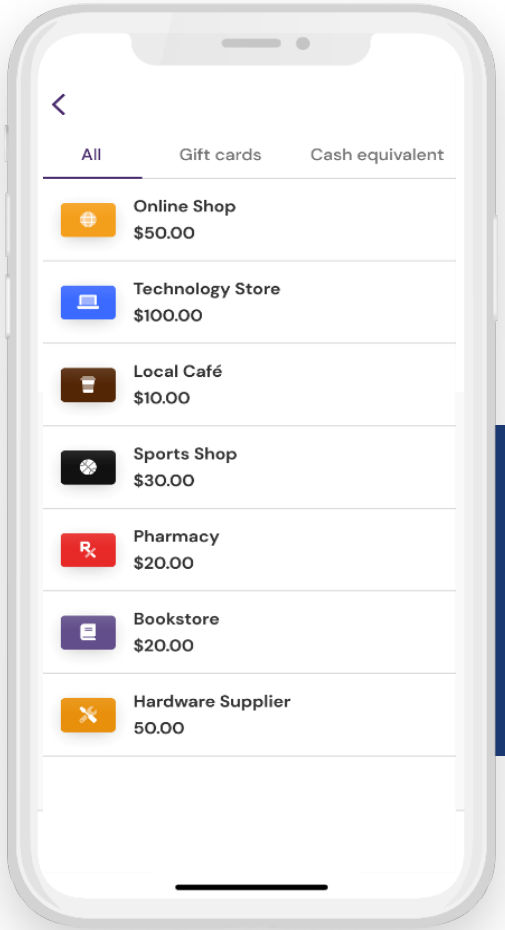
Our **wearable device integrations** allow employees to connect their favorite device or app to sync automatically with TELUS Health Wellbeing for a seamless and secure tracking experience.

- More than 300 devices and apps supported.
- Seamless user experience.
- Ingested data influences risk scores, machine learning engine & personalization.
- Standardized ontology for measuring sleep and wellbeing patterns.

Activity Tracking

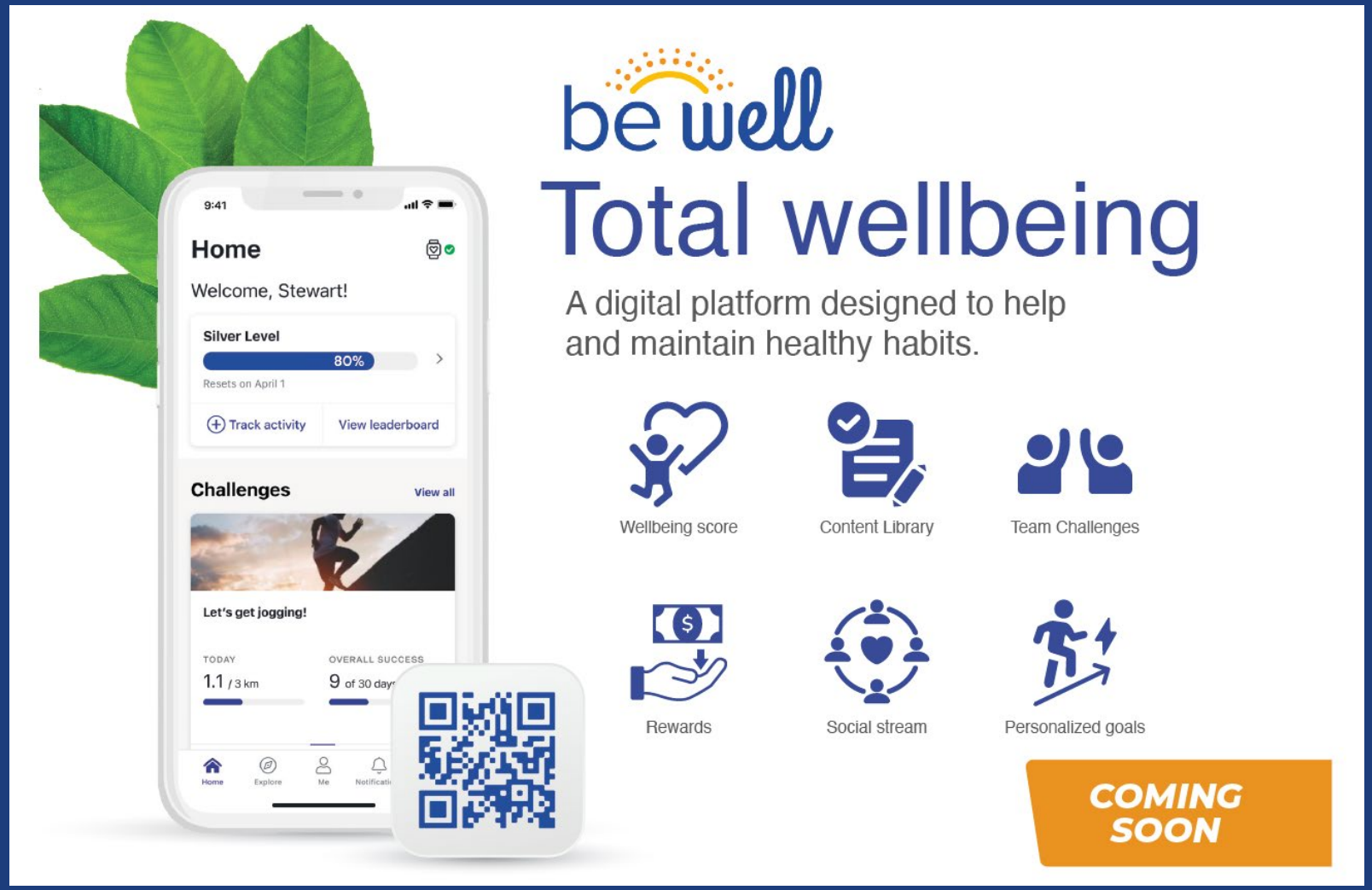
Our customized activity tracker allows for manual user input and provides a holistic offering of activities to encourage employees to embrace new healthy behaviors.

Rewards & Incentives



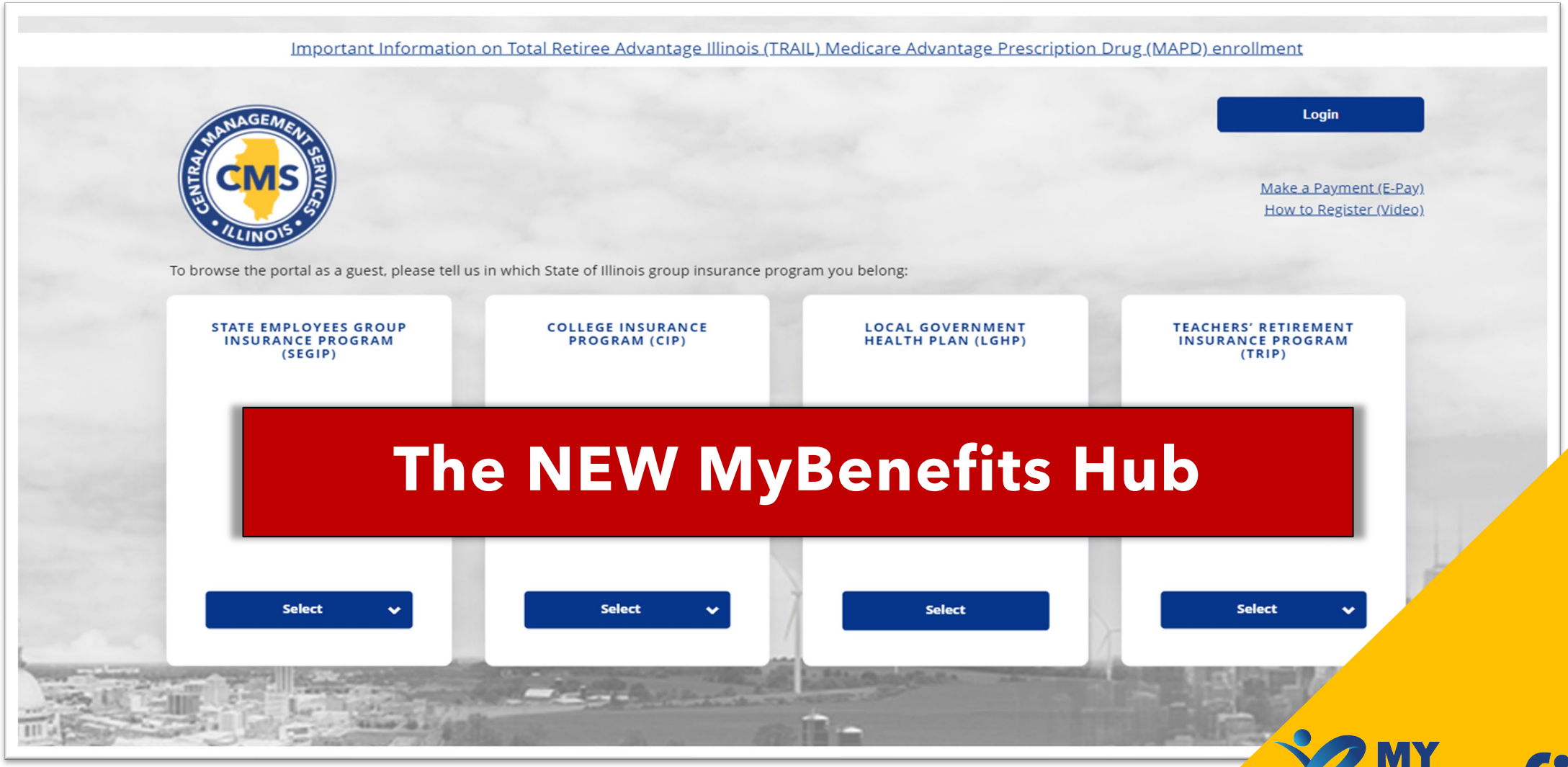
Instant rewards for tracking healthy behavior! Our reward features are built into the platform to recognize healthy behaviors.

- In-app product and gift card redemptions



Next Steps

- Watch for the official launch communication coming from your BeWell Team.
- Use the QR code on today's flyer to register and encourage your peers to do the same!

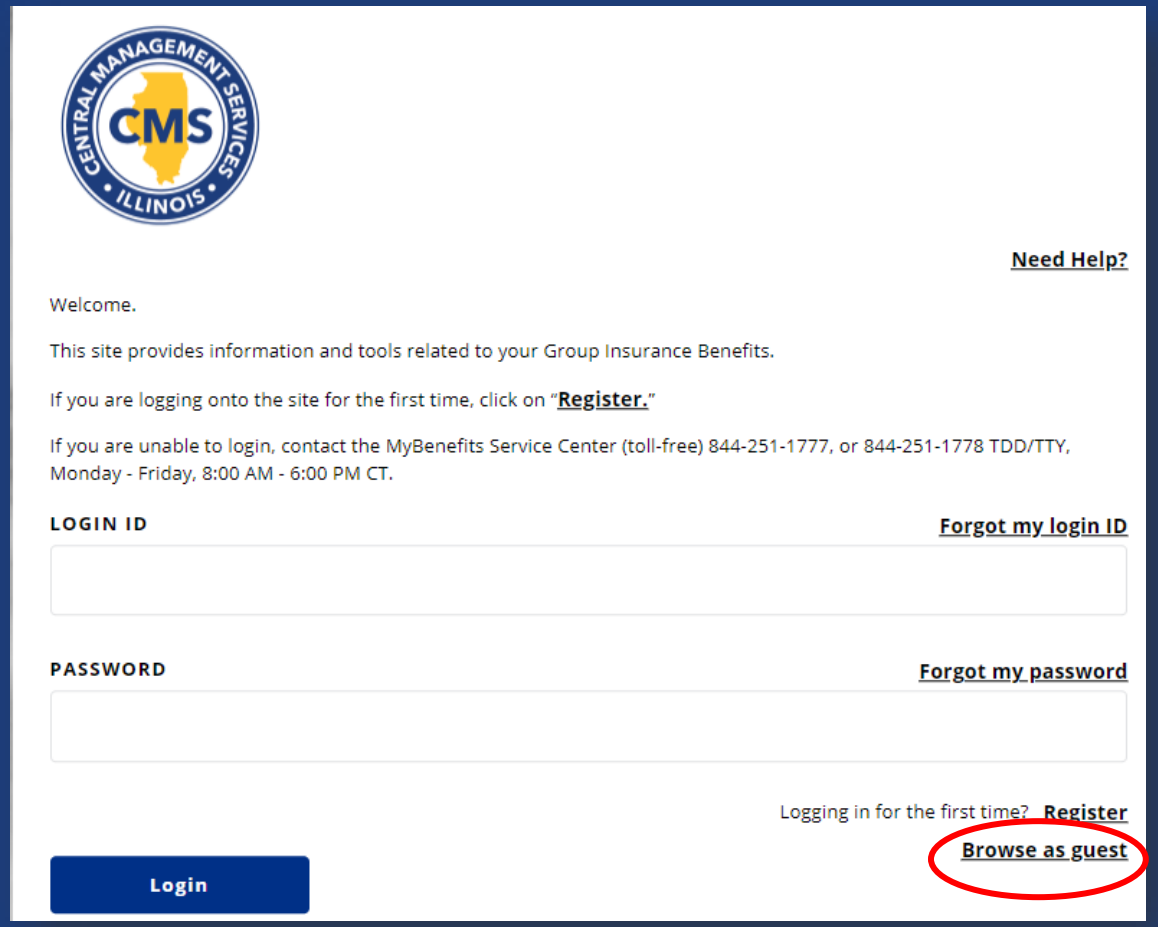


The NEW MyBenefits Hub

ILLINOIS CENTRAL MANAGEMENT SERVICES

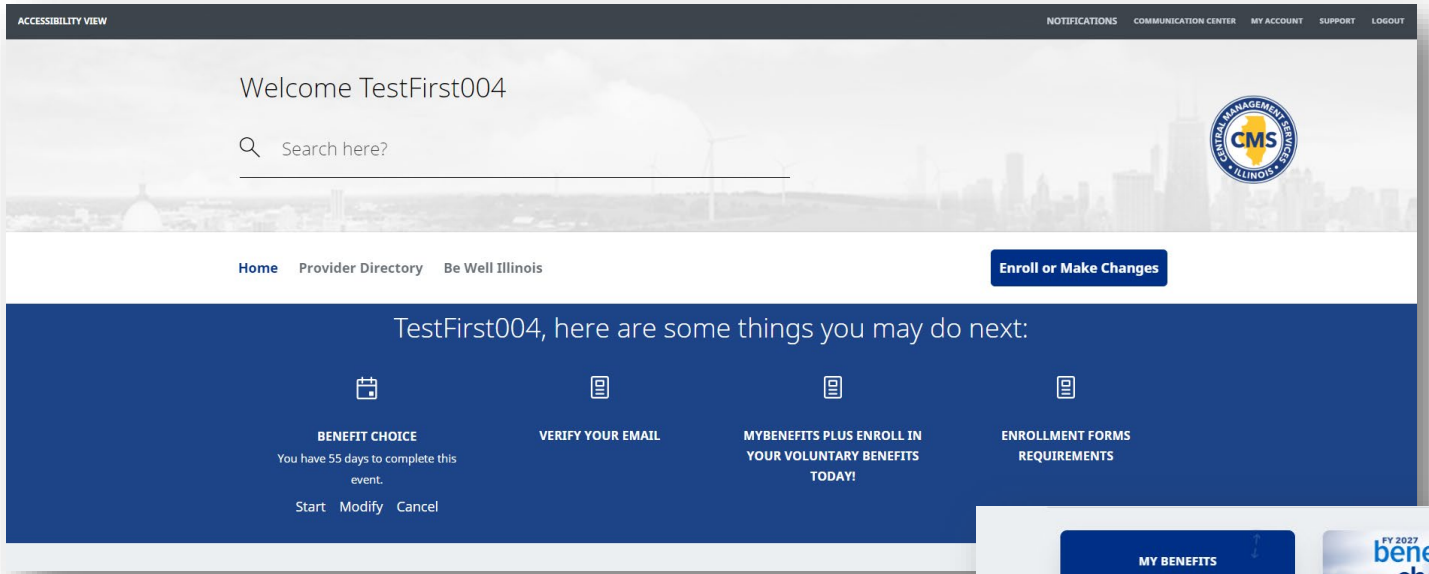
MY Benefits

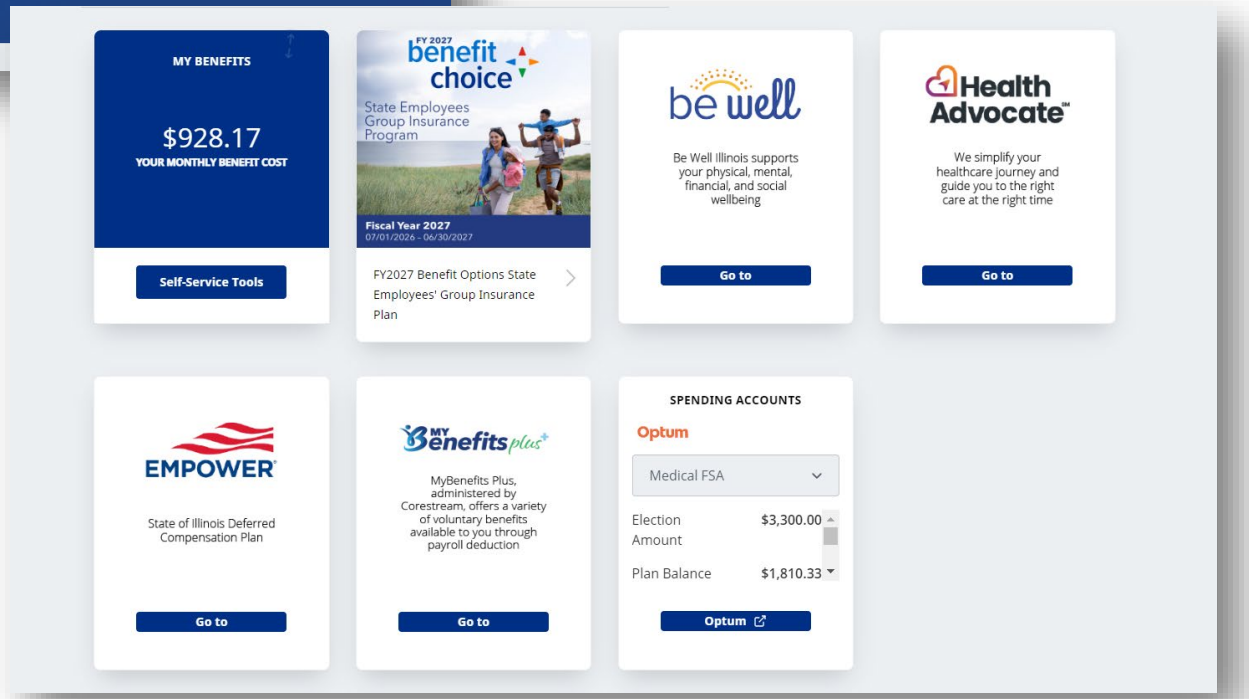
Employee ID



EEID is used to login to the MyBenefits site.

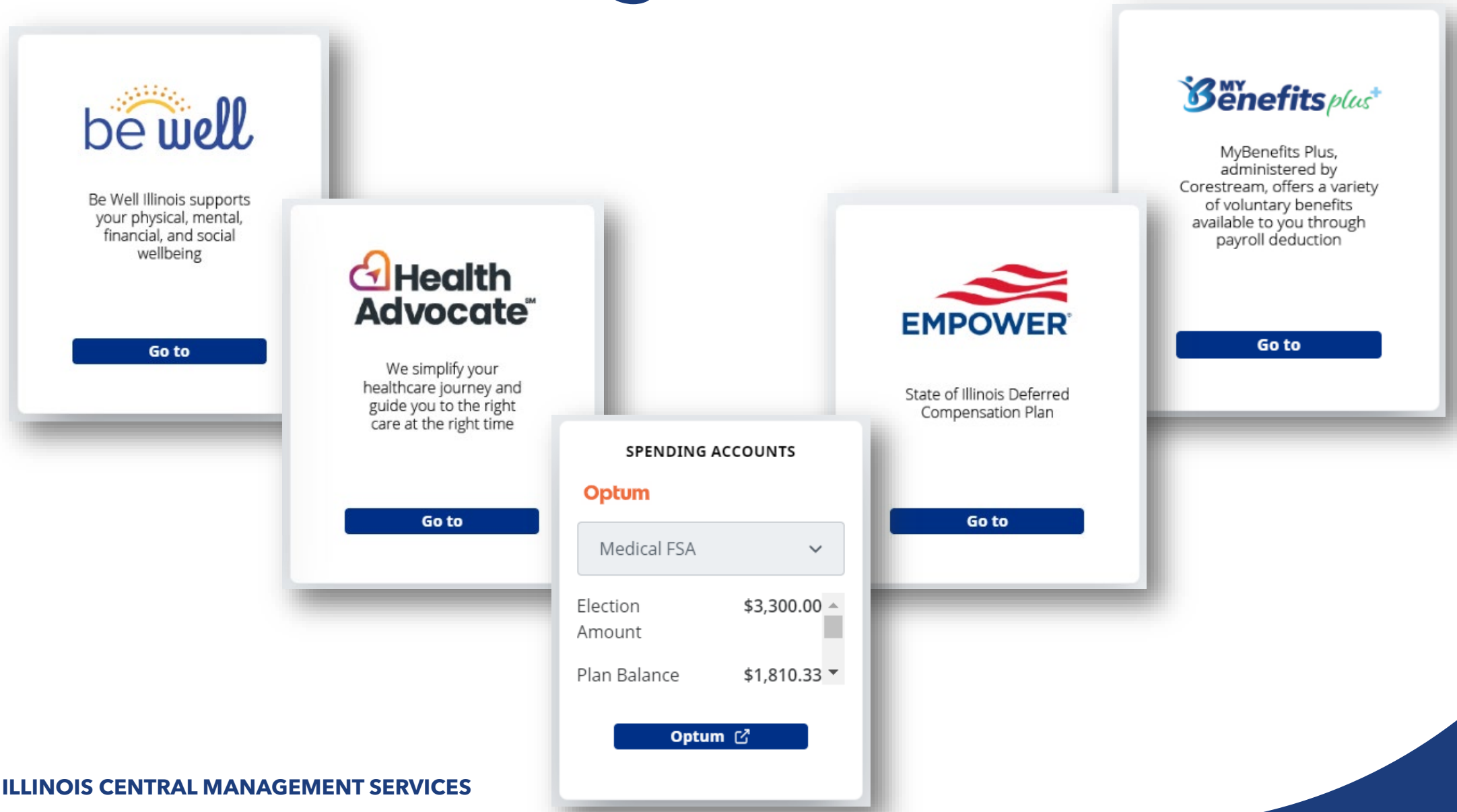
- Forgot my password.
- Browse as a guest.



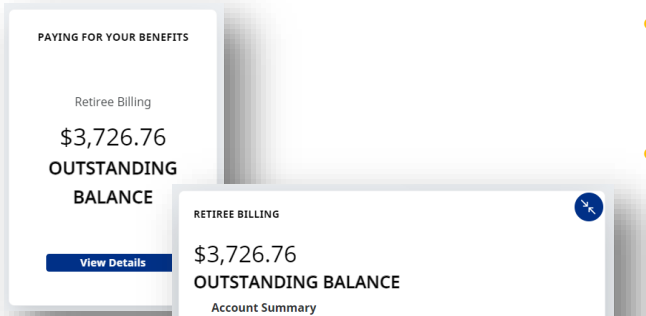


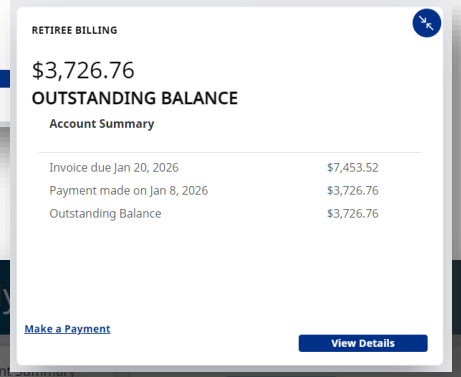
- New look and feel of the MyBenefits site.
- Updated widgets on the home page with new resources for employees.
- Self-Service Tools for reporting QLE's.

MY Benefits Widgets

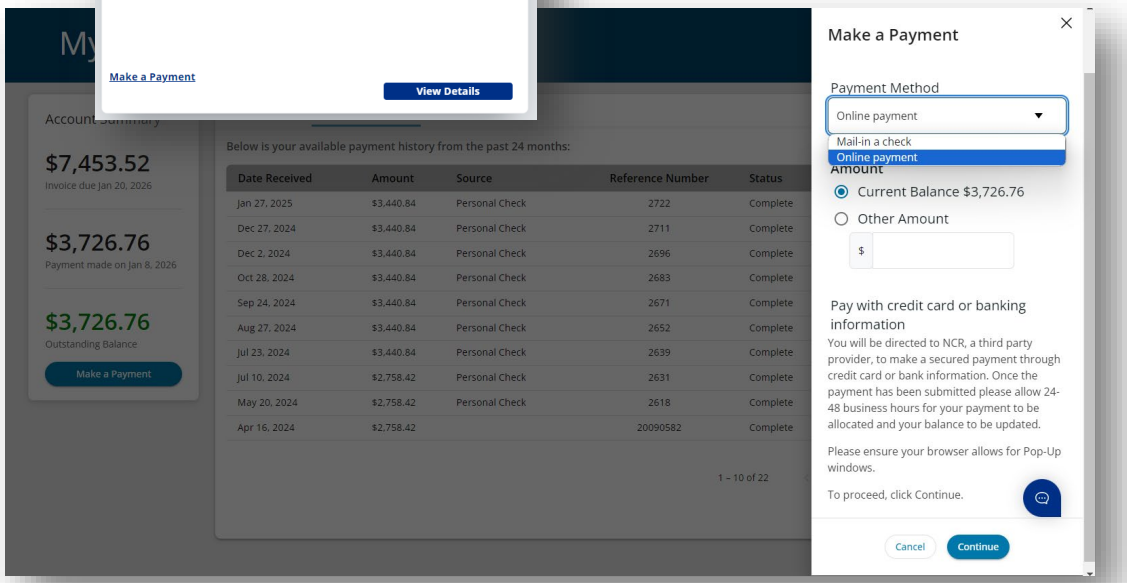


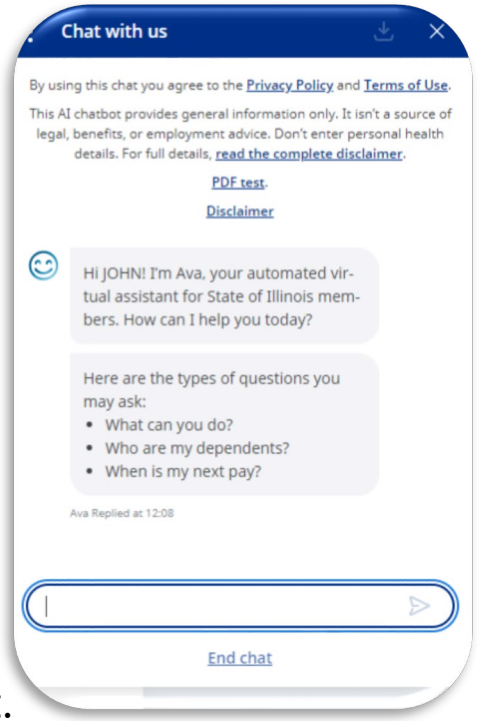
MyBenefits Widgets/Tools





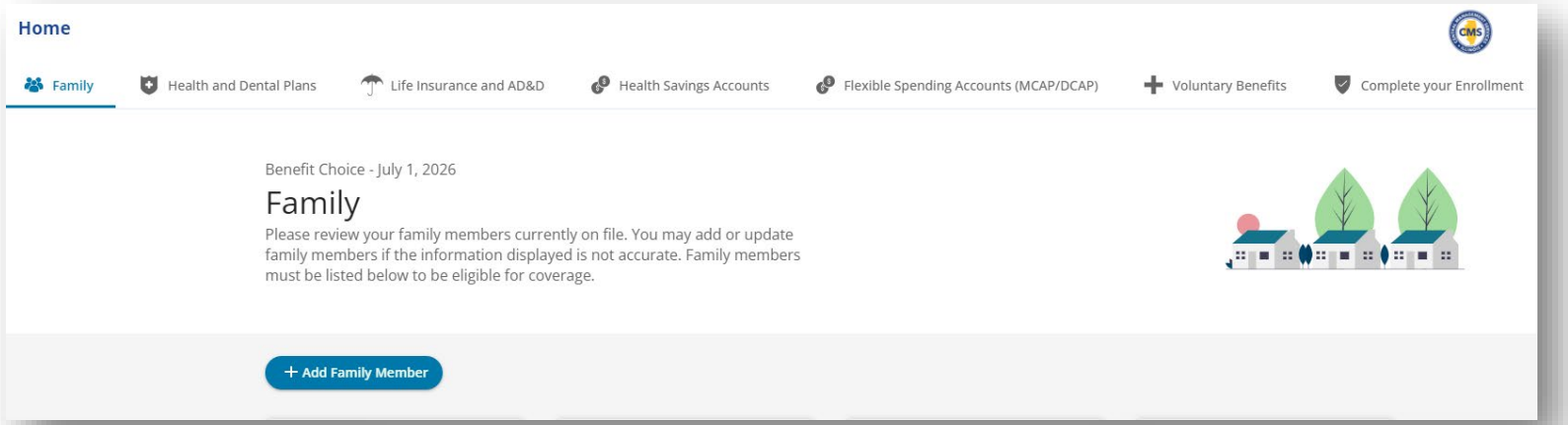
- Billing balance display on billing widget.
- Historical billing and payment info available to members.
- Link to payment vendor for online payments.

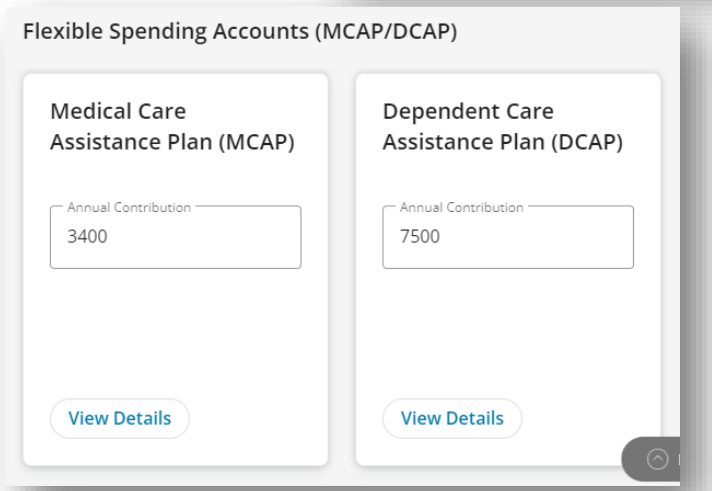




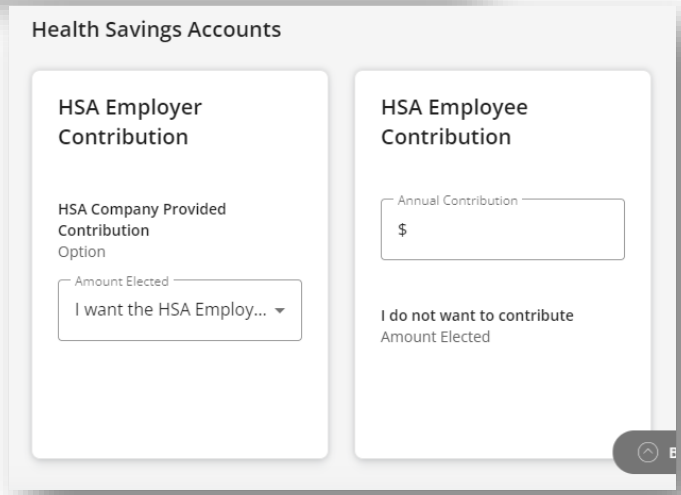
- AVA chat bot.
- Available throughout member enrollments and on MyBenefits site.

Benefit Choice Enrollment





- The tabs are located at the top of the enrollment flow.
- The first step in the enrollment process is to review and add dependents, if needed.
- **Optional Tax Programs (MCAP, DCAP, HSA) must be re-enrolled in each year for continued participation.**



Benefit Choice Enrollment

Benefit Choice - July 1, 2026

Life Insurance and AD&D

- Only life coverage options available to members will be displayed.
- Certain life insurance changes require approval through a Statement of Health.
- Statement of Health approvals/denials are handled by MetLife.

Important information

- Optional Member Life
- Optional Spouse Life

You have applied for Optional and/or Spouse Life and you are required to complete the Statement of Health application. A link to complete the Statement of Health application will be provided on your enrollment confirmation page at the end of your enrollment. The Statement of Health application must be completed with MetLife and the selected benefit level must be approved prior to coverage taking effect. Your Monthly Cost shown is assuming approval of your selected coverage option.

If you do not complete your Statement of Health, by using the link at the end of the enrollment, you must do so within 60 days of your election. You can complete this form at a later date by using the link under Self-Service Tools, View Required Documents. Your coverage will not take effect until approved by MetLife.

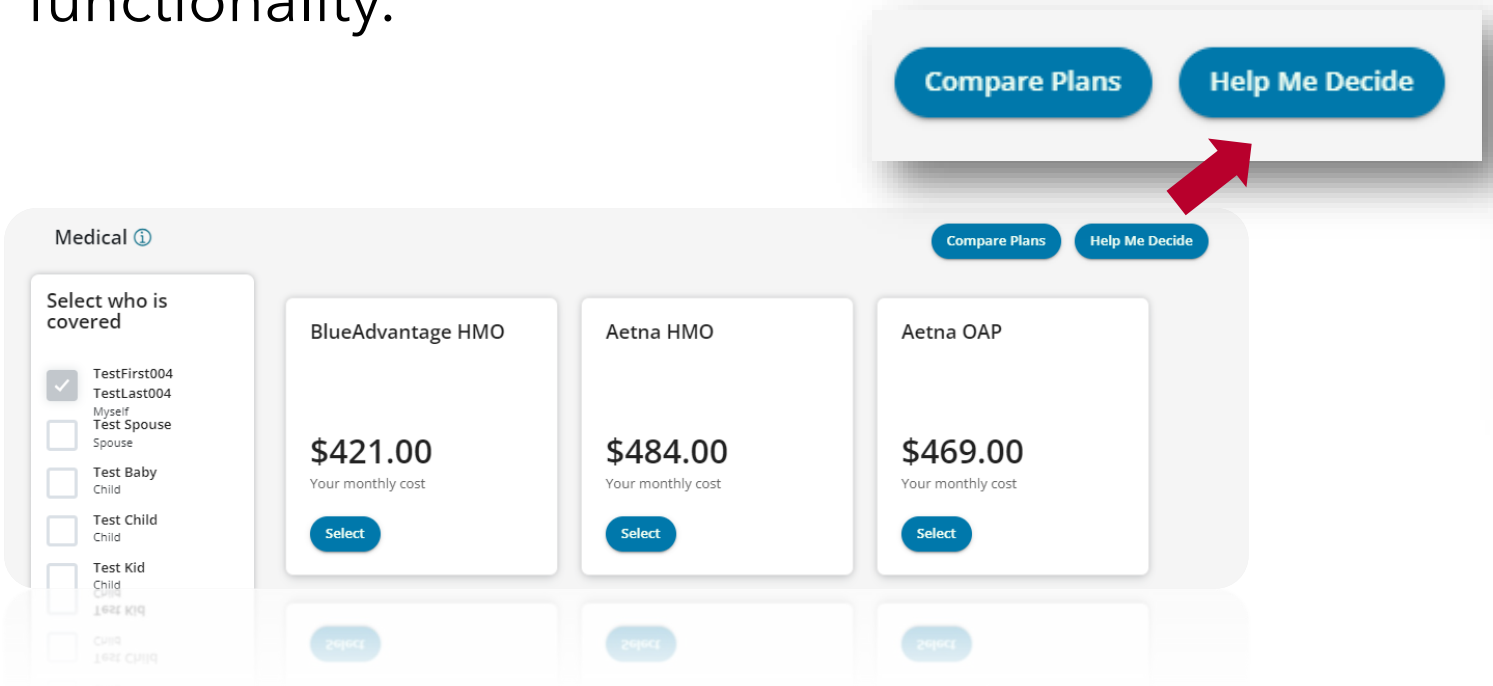
Optional Life and AD&D

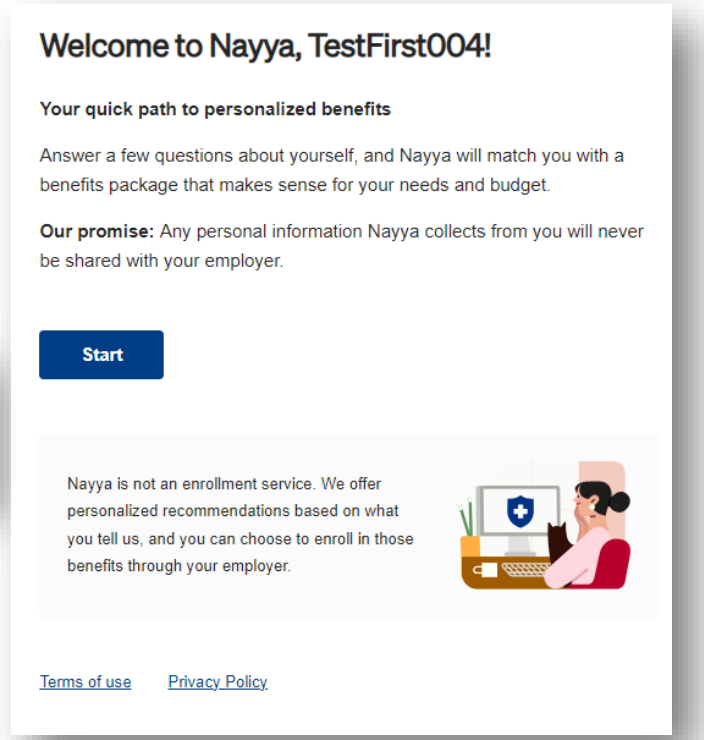
Optional Member Life	Optional Spouse Life	Optional Child Life	Optional Accidental Death and Dismemberment (AD&D)
$180.00	$5.70	$0.60	$25.00
Your monthly cost	Your monthly cost	Your monthly cost	Your monthly cost
Coverage level: 6 x Annual Base Salary	Coverage level: $10,000 Spouse Life	Coverage level: $10,000 per Child	Coverage level: Match Total Life Amount
$1,500,000.00 Amount Elected	$10,000.00 Amount Elected	$10,000.00 Amount Elected	$1,250,000.00 Amount Elected

Back to top

Decision Support Tool

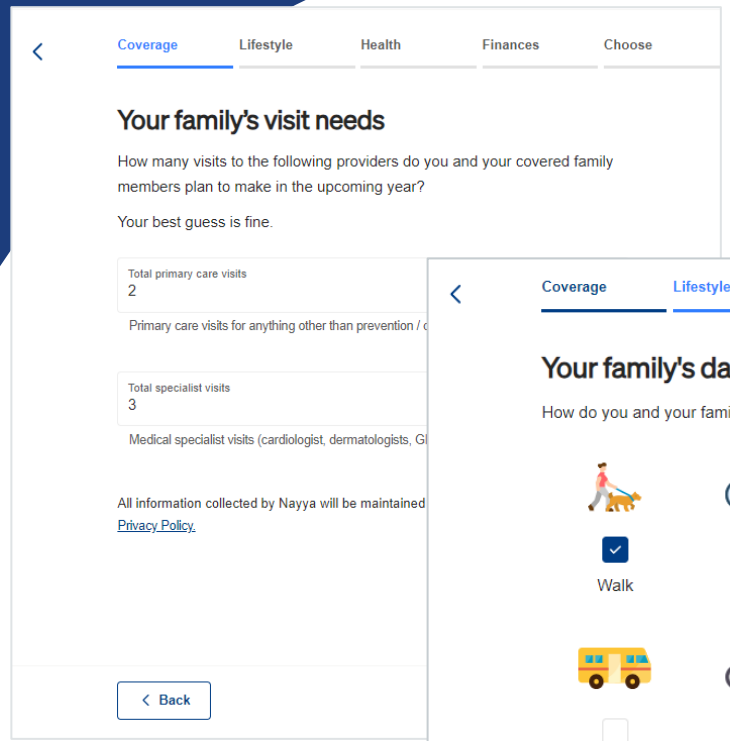
- Enhanced decision support tool within member enrollments.
- Compare plans and ‘Help Me Decide’ functionality.

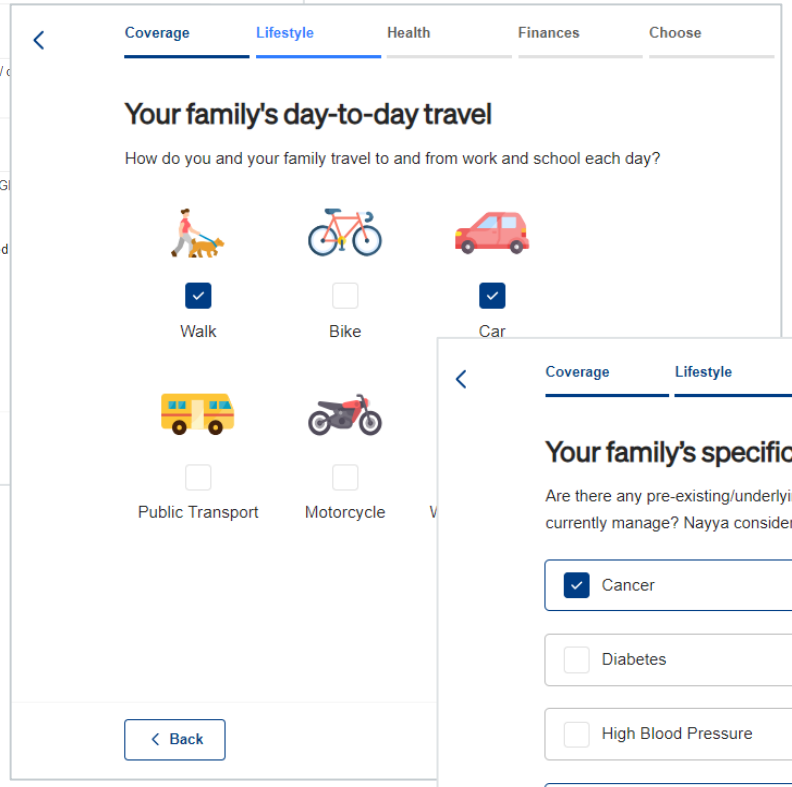


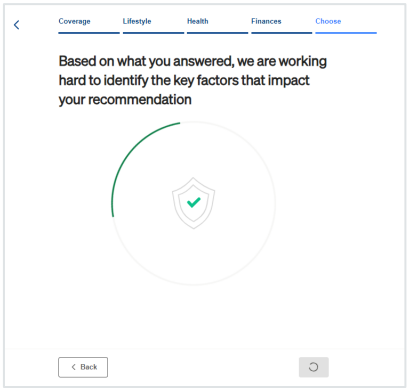


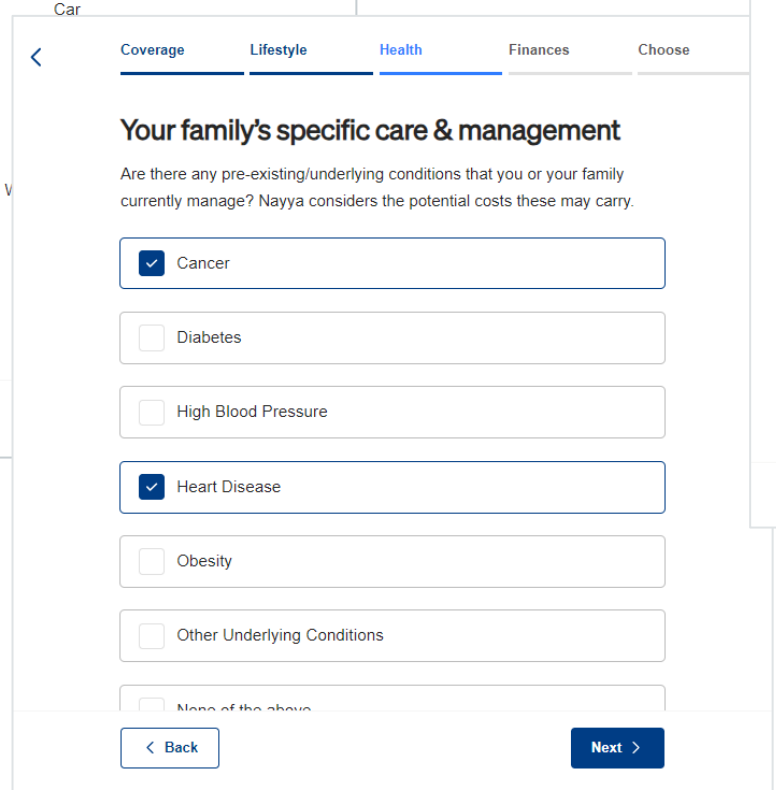
NAYYA

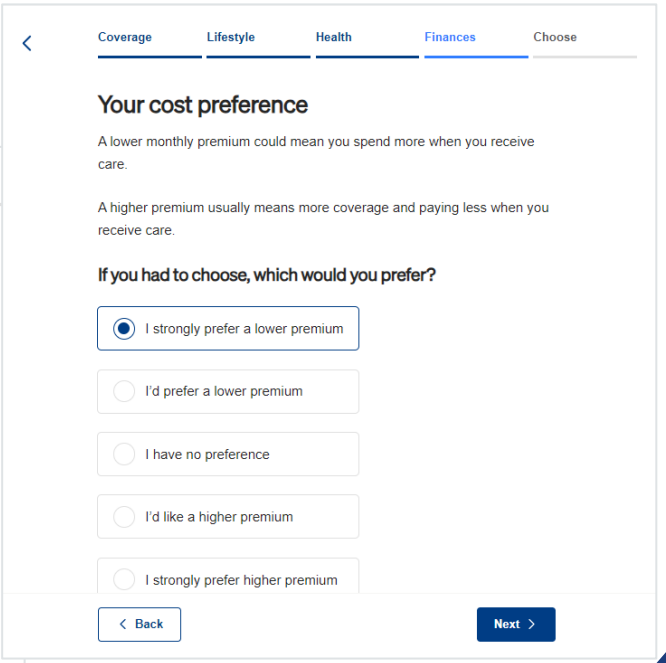
- Evaluates member and dependents health care needs.
- Lifestyle, Health and Finances factored into the personalized experience.



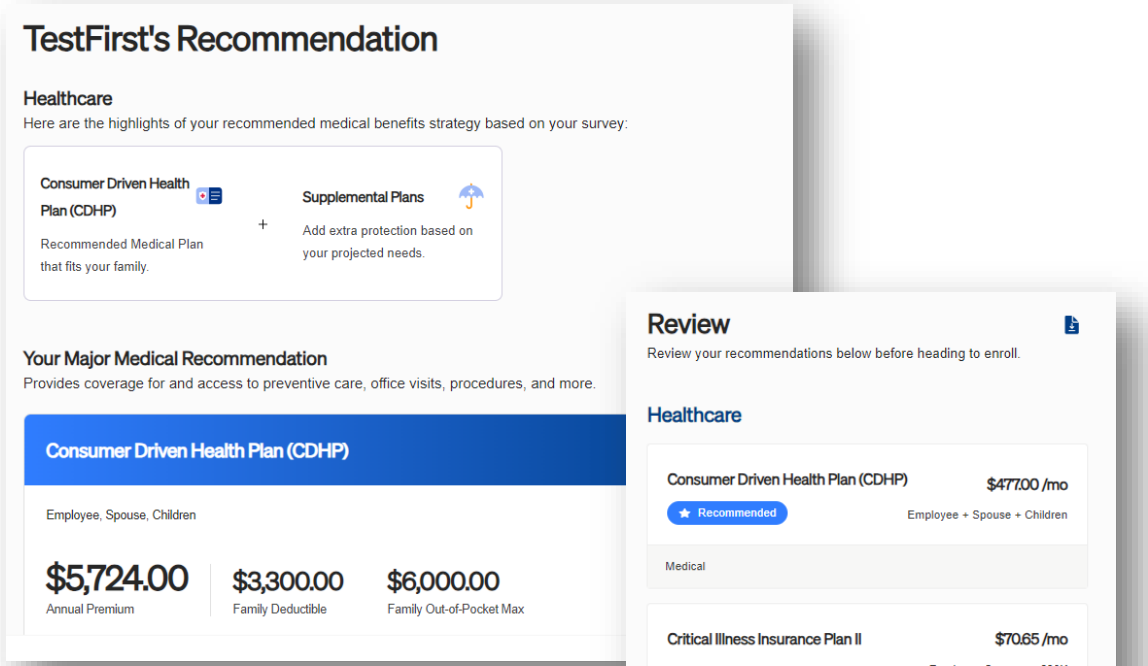




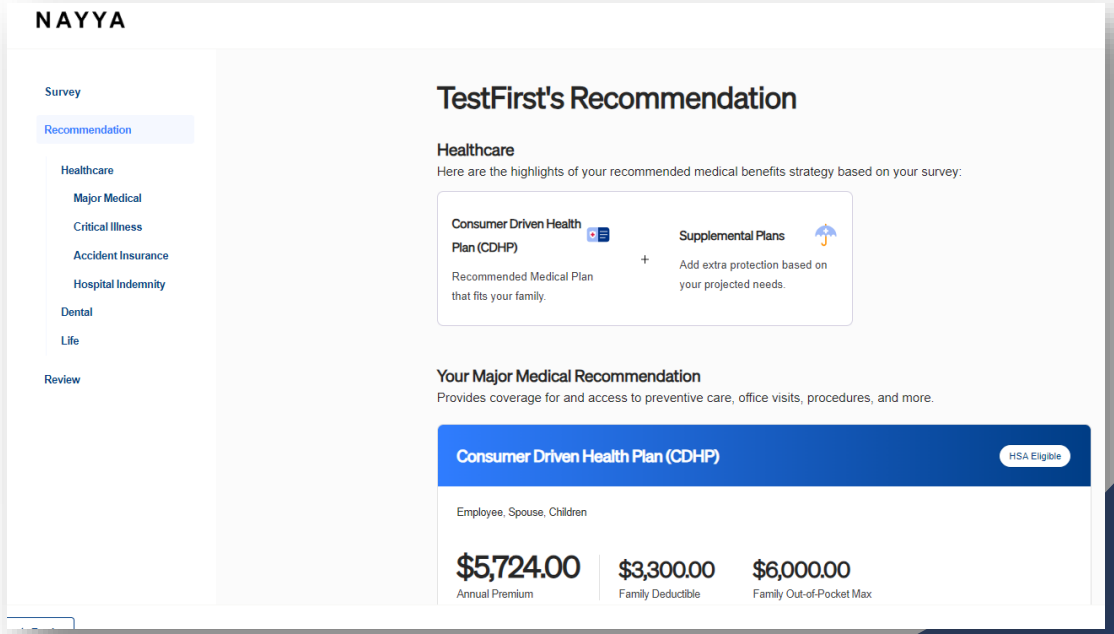




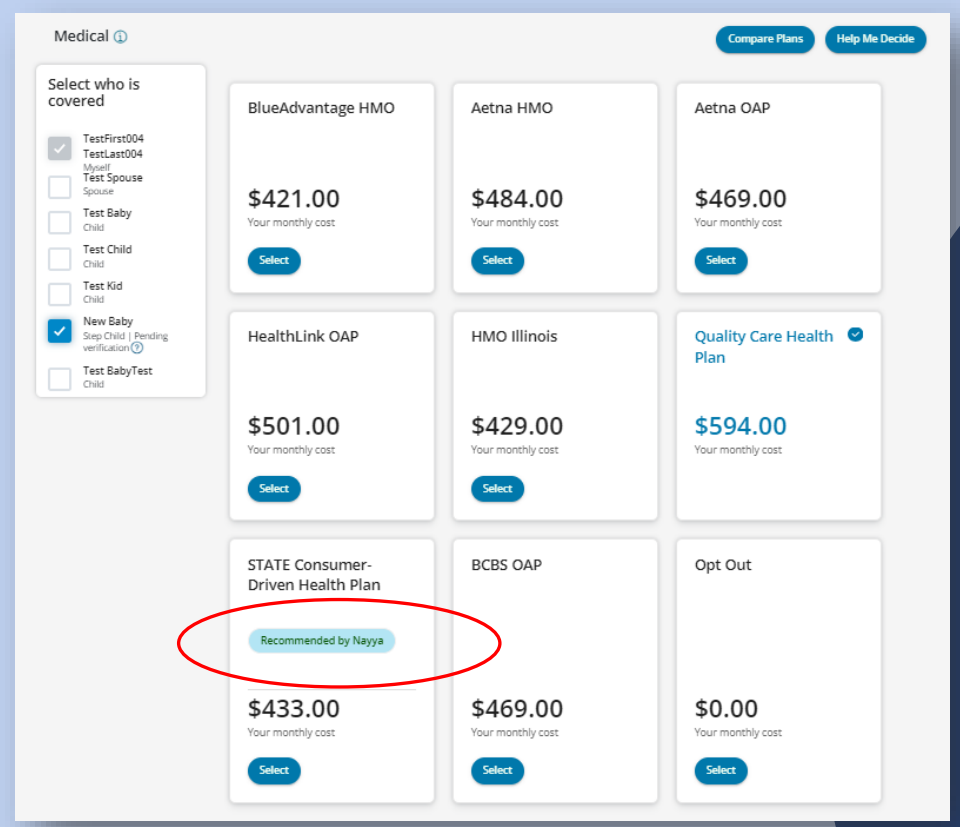
Decision Support Tool

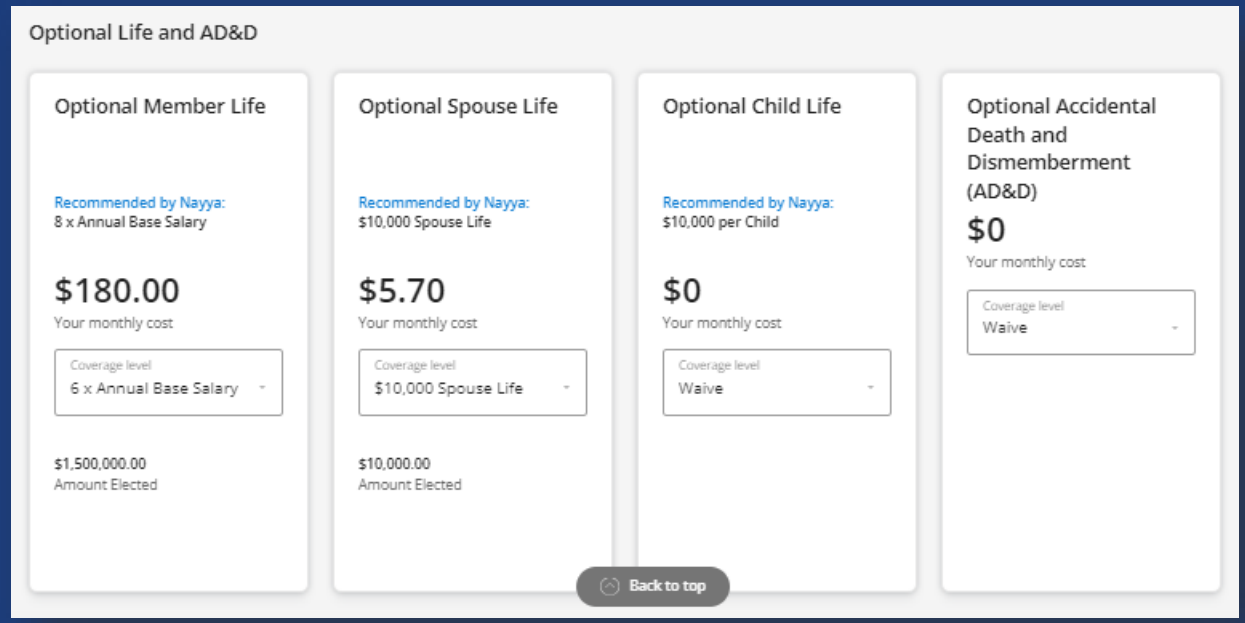


- Recommendations on all areas of coverage.
- Monthly and annual cost breakdown.
- Summary of benefits tied to each recommended benefit



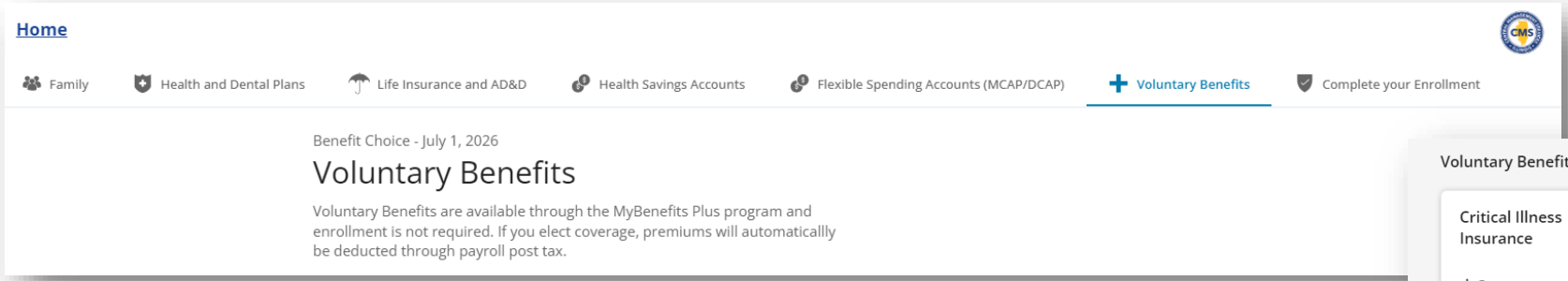
Decision Support

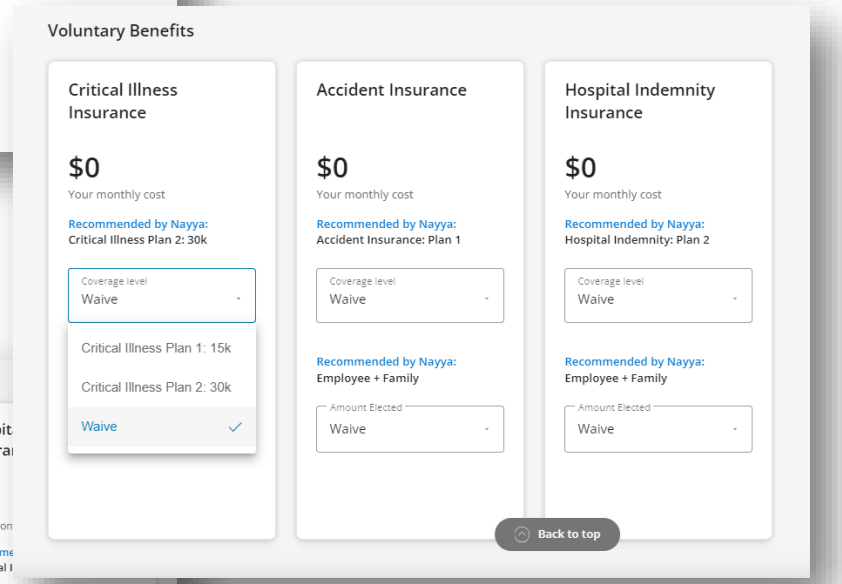


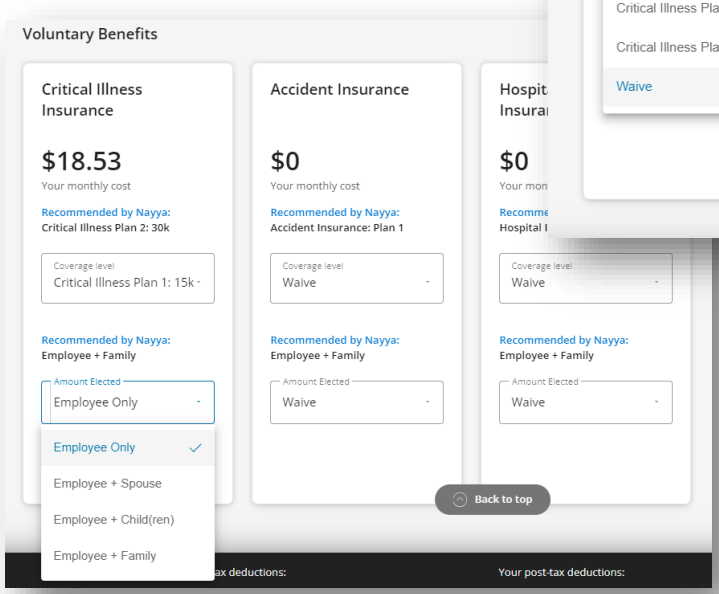


- "Recommended by Nayya" throughout enrollment tool for easy reference.
- Plan compare available for side-by-side plan details.

MyBenefits plus Voluntary Benefits





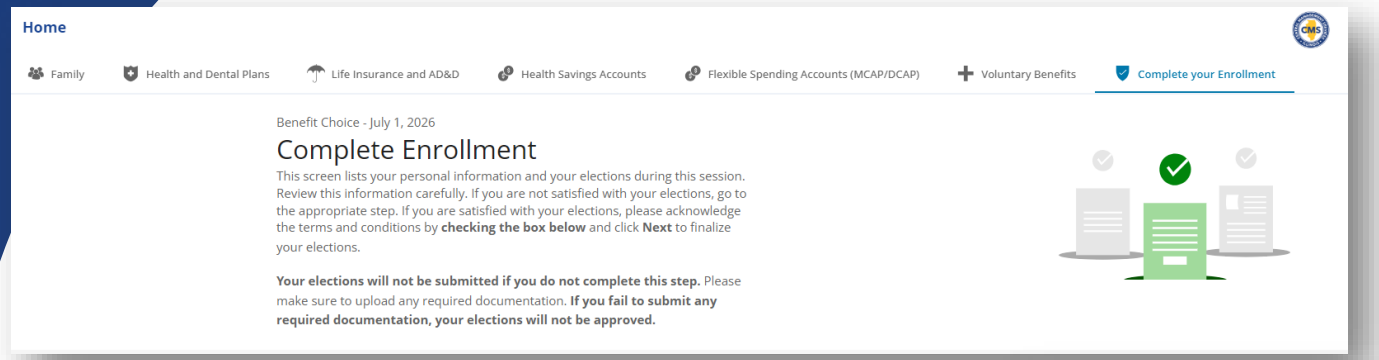


The following voluntary benefit options are available in the enrollment tool:

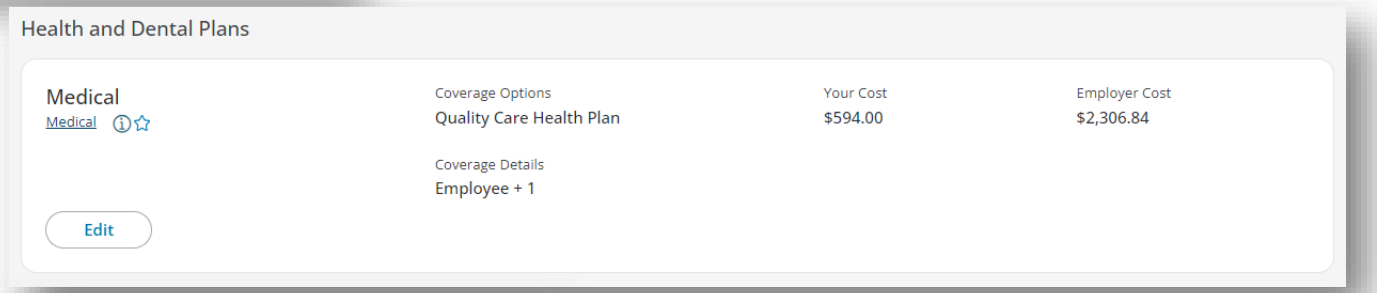
- Accident Insurance
- Hospital Indemnity Insurance
- Critical Illness Insurance

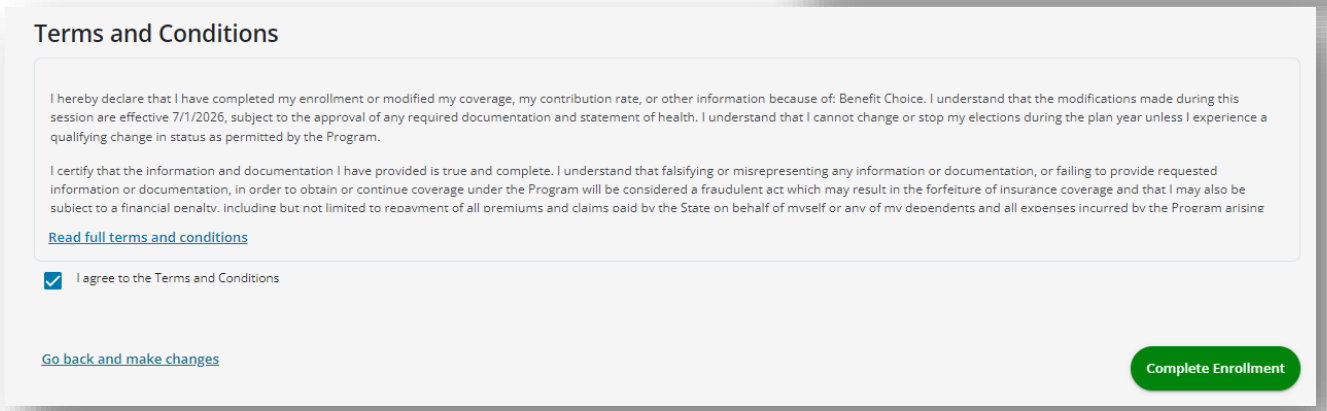
- Payroll deducted.
- Coverage Tier and Coverage Level options based on eligible dependents.

Complete Enrollment

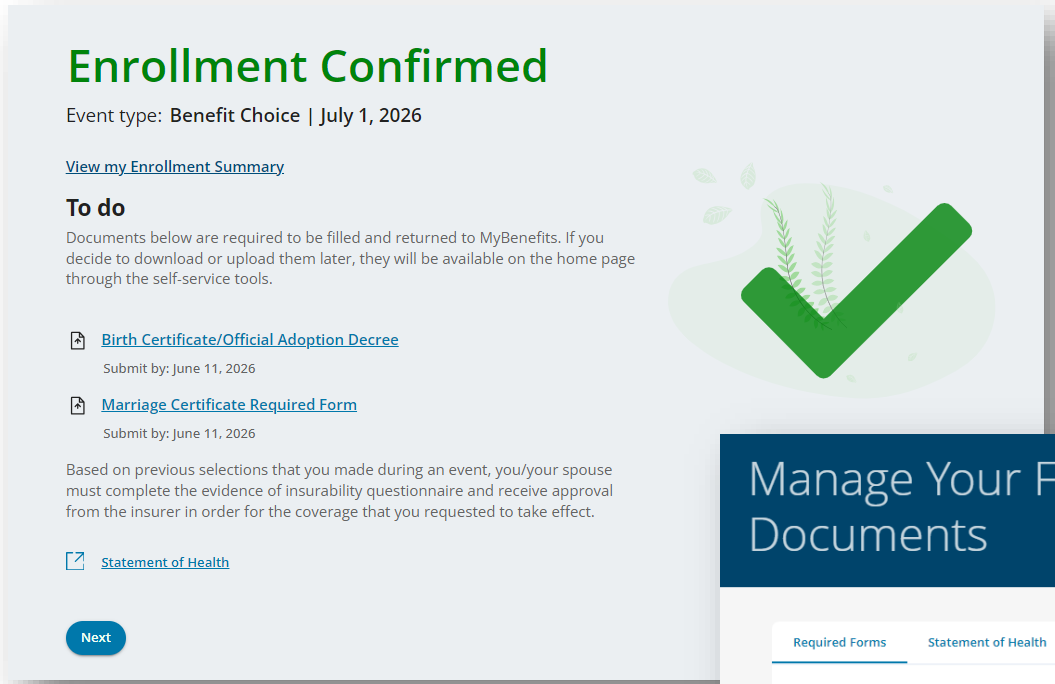


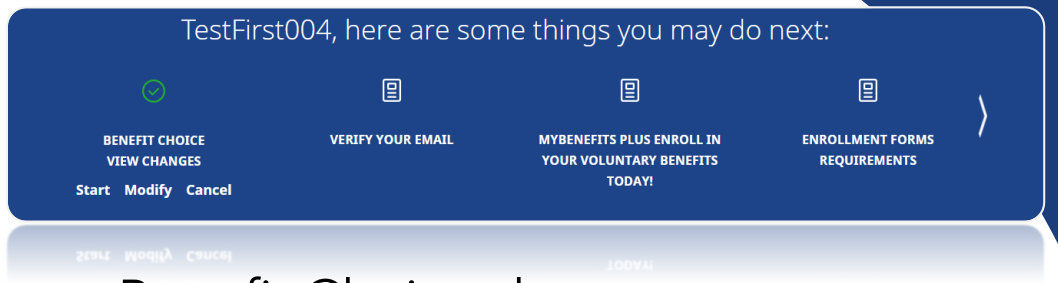
- Review of any changes to coverage.
- Summary of cost.



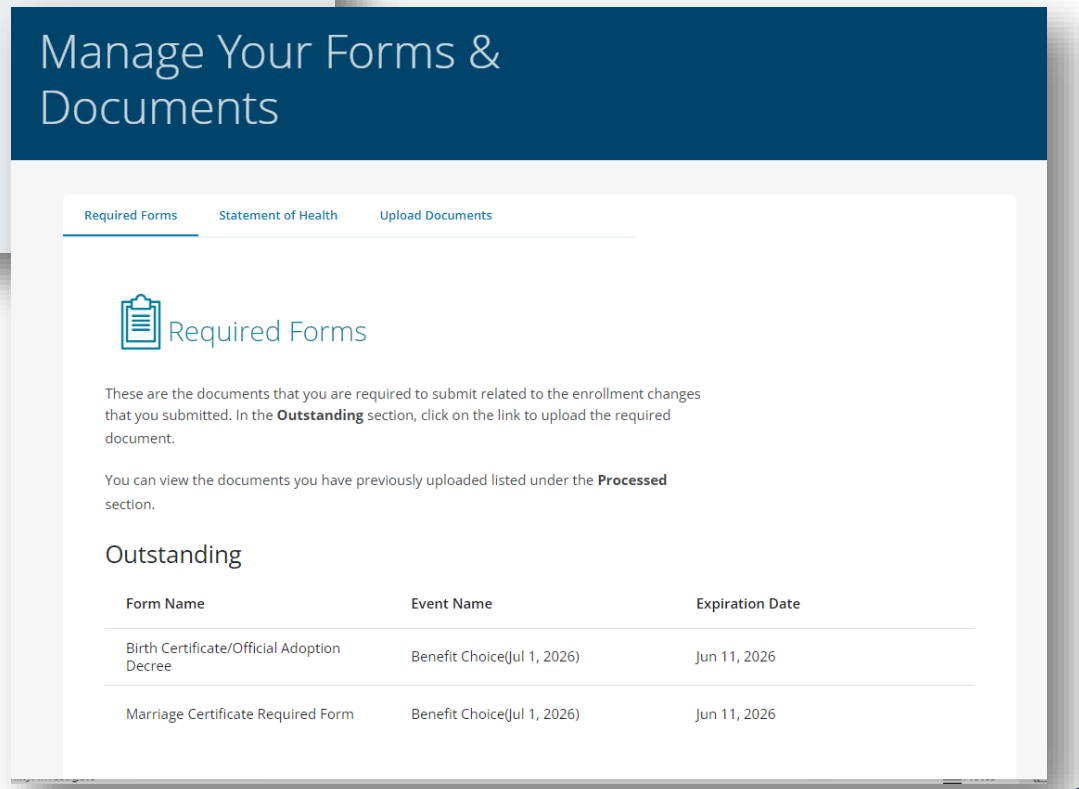


- Terms and Conditions must be agreed to by checking the box.
- "Complete Enrollment" button must be clicked.



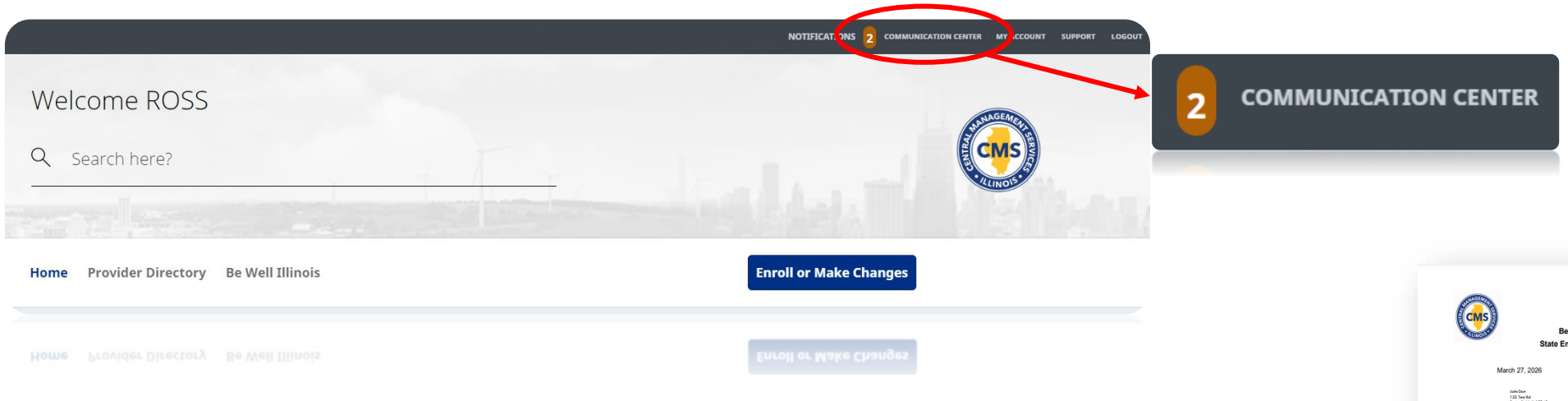


- Benefit Choice shows green on call-to-action bar.

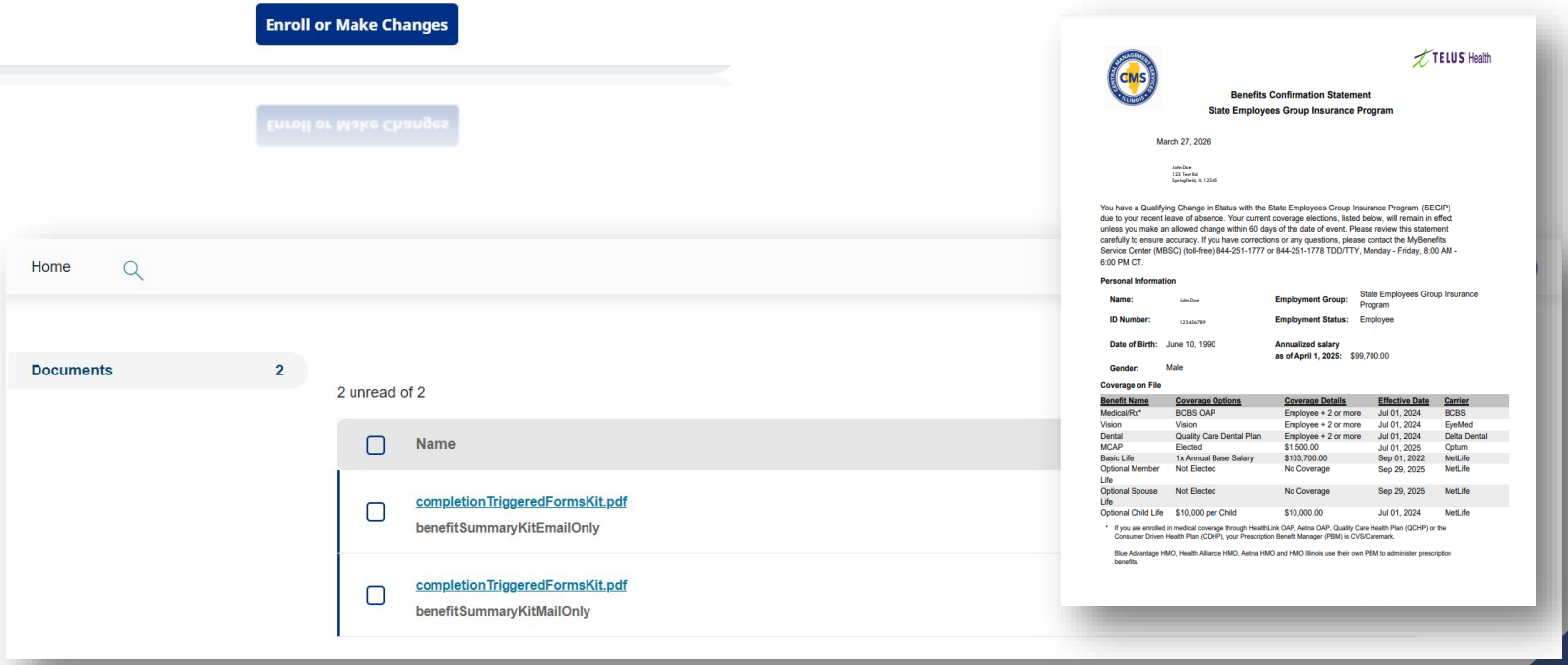


- Required documentation displays on “Enrollment Confirmation” page and must be **uploaded by June 11, 2026**.
- Forms can be uploaded on “Manage Your Forms & Documents” page.

Communications Center



- Members able to view communications tied to account.
- Confirmation statements and other forms can be opened and printed.
- ***E-mail preference now available.***



MY Benefits plus

Evergreen/Anytime Elections

Gradfin
Home & Auto Insurance
Discount Shopping
Identity Theft Protection
Personal Loan Program
Pet Health Insurance
Purchase Financing
Student Loan Refinancing

Open Enrollment/New Hire Event

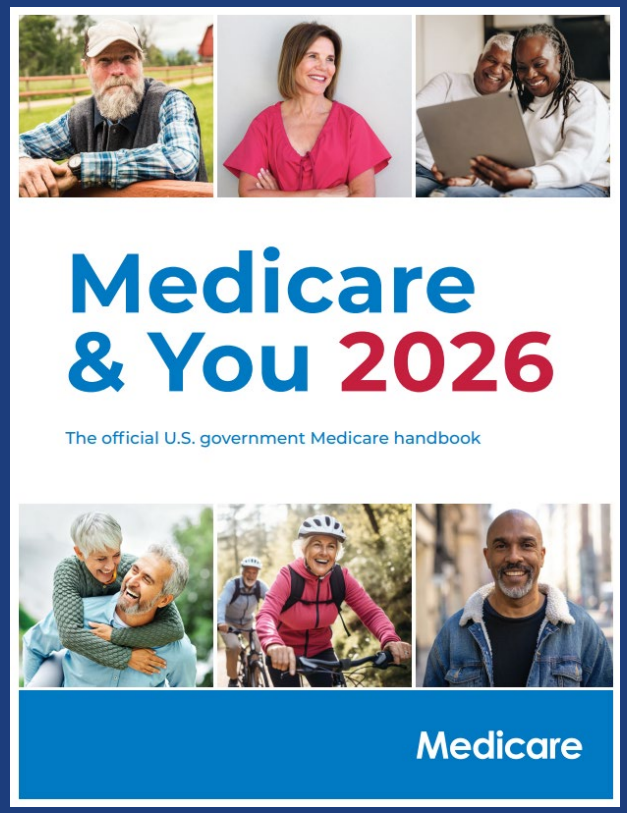
Accident Insurance*
Critical Illness Insurance*
Hospital Indemnity Insurance*
Legal Services
Life with Long-term Care
Long-Term Disability Insurance
Pet Wellness
Short-Term Disability Insurance

***Enrollment is now available through MyBenefits.**

Scan to access the MyBenefits Plus Site

5/1/2026

Are you actively working & closely approaching age 65?



You must contact SSA and APPLY for Medicare Part A three months prior to your 65th birthday.

- You are not REQUIRED to ACCEPT Part A;
  - However, if it is free to you, there is no reason not to accept it.
  - This will also prepare you for Part B when you retire.

You must sign up for Medicare Part B three months prior to their retirement date.

- Provide all Medicare coverage information to the MCOB Unit: CMS.Ben.MedicareCOB@illinois.gov
- For Medicare questions, call the MCOB Unit: 217-782-7007

Facts about TRAIL MAPD:

- The State-sponsored TRAIL MAPD plan includes the benefits of Medicare Part A, Part B and Part D (prescription drug coverage).
- Waiving the TRAIL MAPD coverage does not allow enrollment in a non-Medicare retiree plan.
- The TRAIL MAPD Plan REQUIRES continued payment of Medicare premiums to the SSA.

Split Family Coverage Applies to Retirees Only

- As of July 1, 2025, Medicare-eligible retirees were no longer able to remain covered under a non-Medicare retiree plan. Instead, accounts that had both Medicare and non-Medicare eligible plan participants resulted in split family coverage; where family members are enrolled in different health plans.
- A Medicare-eligible retiree will have to enroll in TRAIL MAPD, and their covered non-Medicare dependent(s) will remain in a non-Medicare retiree plan.
- A non-Medicare retiree will remain in a non-Medicare retiree plan, and their Medicare-eligible dependent(s) will have to enroll in TRAIL MAPD.
- Exception: SEGIP retirees, annuitants, or survivors with two (2) or more covered dependents will not be subject to Split Family until their coverage level becomes Retiree +1 or all covered dependents become eligible for Medicare due to age or disability.

Medicare Requirements for SEGIP Members

- Medicare Due to Age:
  - All plan participants are required to contact the SSA and apply for Medicare benefits three months prior to turning age 65.
  - If the SSA determines that a plan participant is eligible for premium-free Medicare Part A and the member is a retiree, annuitant, survivor, or not actively working due to disability, the plan participant is required to accept the Medicare Part A coverage and enroll in Medicare Part B.
  - Dependents are still required to enroll in Medicare Part A upon meeting eligibility requirements, regardless of the member's employment status.
- Medicare Due to Disability:
  - Plan participants who become eligible for Medicare disability benefits are required to accept the Medicare Part A coverage.
  - Plan participants can delay enrollment into Medicare Part B until the member retires or loses current employment status due to a disability-related leave of absence. At that time, the State requires the plan participant to enroll in Medicare Part B.

Medicare Requirements for SEGIP Members

- Medicare Due to End Stage Renal Disease (ESRD):
  - Plan participants who become eligible for Medicare benefits on the basis of ESRD are required to accept the Medicare Part A coverage.
  - Plan participants covered due to active employment can delay enrollment in Medicare Part B until the end of the 30-month ESRD coordination period. At that time, the State requires the plan participant to enroll in Medicare Part B.

- Once enrolled in Medicare, the member and/or dependent is required to send a copy of the Medicare card to the MCOB Unit.
- 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, the member must request a written statement and forward to the MCOB Unit to avoid a financial penalty.

- SEGIP and CIP plan participants **who are eligible to enroll** in Medicare Parts A and B due to age or disability **are required** to enroll in the TRAIL Medicare Advantage Prescription Drug (MAPD) when first eligible.

- TRIP plan participants **who are enrolled** in Medicare Parts A and B due to age or disability **are required** to enroll in the TRAIL MAPD Program when they are first enrolled in Medicare.

- For ALL: Failure to enroll in TRAIL will result in the termination of coverage for the member and any covered dependents. If the dependent is eligible, failure to enroll in TRAIL will result in the termination of the dependent's coverage.

trail

TOTAL RETIREE ADVANTAGE ILLINOIS