Benefit Choice Enrollment: May 1-31

Member benefit information
Two years ago, CMS published a new state of Illinois Benefits Handbook (effective July 1, 1997 – June 30, 2000) which was distributed to employees in campus mail fall 1997. Please keep that handbook and the new Benefit Choice Options booklet (effective July 1, 1999 – June 30, 2000) along with this newspaper. Together, these items should provide all the relevant information you need regarding state plan benefits.

Employees enrolled in an HMO also should receive information from the HMO detailing its benefits and plan provisions.

The telephone enrollment system
See “Make your change by phone” under briefs on page 7.

NESSIE, a university Web-based application (http://nessie.uhrs.uiuc.edu), may be used to make changes until 10 p.m. June 1. See page 7 for more information and training sessions.

Enrollment worksheet returned to the Benefits Center. You should receive this worksheet in campus mail.

If you decide not to make any changes, no action on your part is necessary. Your present enrollment will continue automatically, except for the Medical and/or Dependent Care Assistance plans. Both of these plans require re-enrollment each year.

Don’t be late! (Irrevocability rule)
Any changes that you want to make during the Benefit Choice enrollment period must be submitted May 1 through June 1. The last day you can personally deliver forms to the Benefits Center is June 1. We are permitted to accept changes sent through the U.S. Postal Service (USPS) if postmarked on or before June 1. For example, assume the Benefits Center receives two forms on June 3, 1999 – one sent by campus mail and the other by the U.S. Postal Service. Regardless of when the form received in campus mail was signed and sent, the Benefits Center cannot accept it. However, if the form sent by U.S. Postal Service was postmarked on or before June 1, the Benefits Center can accept it.

Also, remember that the state’s telephone enrollment system can be used to make changes until midnight on May 31 and NESSIE will be available until 10 p.m. June 1.

The reason for the inflexibility in these deadlines is the state of Illinois Premium Payment Plan. Under this plan, payroll-deducted premiums members pay for health, dental and life coverage are tax exempt. The Internal Revenue Service code requires plans with the tax-exempt premium to prohibit changes in the member’s deduction during the plan year unless there is a qualified change in family status, special enrollment period or other special circumstances. This Irrevocability Rule is required pursuant to Section 125 of the Internal Revenue Code. If the state is not in compliance (accepts forms late), the plan could lose its qualification and/or employees could be subject to an Internal Revenue Service audit and be required to pay additional taxes and possible penalties.

SURS Retirement Options
On July 1, 1998, two new State Universities Retirement System (SURS) plan options became available to UI employees in addition to the Traditional Benefit Package.

The three SURS options:

1. SRS Traditional Benefit Package maintains the same benefit and contribution provisions as existed before July 1, 1998.
2. SRS Portable Benefit Package is much like the existing SURS Traditional Benefit Package but provides a more generous account-balance refund if you terminate your employment and move elsewhere.
3. SRS Self-Managed Plan establishes an account in your name into which both employee and employer contributions will flow; you decide how your account balance will be invested, selecting from among a variety of mutual funds and other investment options for that purpose. Eligible employees have received a Choice Kit from SURS. In addition, many have attended campus presentations sponsored by SURS or visited the SURS Web site at http://www.surs.com or the UI’s NESSIE site at http://nessie.uhrs.uiuc.edu.

But have you returned your retirement option election form to SURS? There are very good reasons for completing this form. In a recent publication, SURS noted that completing an election form:

• Allows you to begin your retirement planning today.
• Assures that you will enroll in the plan you want.
• Avoids defaulting into a plan that doesn’t suit your needs.
• Initiates immediate state matching moneys to your account if you select the Self-Managed Plan option.
• Provides important feedback to SURS, that can be used to fine-tune educational materials, presentations and plan for the future of the system.
• Creates a formal record of your choice.

Selecting a retirement option is an important decision. Once you choose an option, your decision is irrevocable; it cannot be changed. To exercise your right to choose the plan that best fits your retirement goals, it is important that you declare your option within the election period, which is determined by your date of hire: 1) within 60 days of your initial employment date if you were hired on or after July 1, 1998, or 2) by June 30, 1999, if you were hired before July 1, 1998.

(See Retirement options, page 7)
Quality Care Health Plan

Medical claims
UNICARE is the claims administrator for the Quality Care Health Plan. Central Management Services (CMS) has instituted the following standard claims processing procedure for UNICARE. After a claim is initially processed, payment to the member or provider is normally expected to occur within six to eight weeks. Previously, CMS instructed the claims administrator to send the member’s Explanation of Benefits (EOB) form at the same time the payment was sent. Now, the EOB is sent to the member when the claim is initially processed but the payment to the member or provider will be sent within six to eight weeks later.

Claims should be filed promptly; however, the plan requires that all claims (medical, pharmacy and mental health/substance abuse treatment) must be filed no more than two years from the end of the plan year in which the charge was incurred.

Service date of claim
Prior to July 1, 1997 .......................... June 30, 1999

Claims should be submitted to:
UNICARE, State of Illinois
Group Number 28455
P.O. Box 3025
Bolingbrook, IL 60440-3025

When is precertification required?
• Non-emergency hospital admission.
• Elective surgery (at least seven days prior to any elective surgery).
• Maternity hospital admission. (See Benefits Handbook.)
• Admission to nursing home or extended care facility/hospital.
• Coverage when Medicare Part A inpatient benefits are exhausted.
• Emergency hospital admission (within two business days).

The penalty for failure to precertify is $400. Call (800) 327-7443.

Prescription claims
National Prescription Administrators Inc. (NPA) is the claims administrator for drug coverage in the Quality Care Health Plan. New members will receive “welcome” packets with cards that contain NPA’s address and telephone number as well as information to assist pharmacies in transmitting a claim electronically. It is expected that one card will be sent to each member, two cards will be provided for those with one or more dependents. The initial card(s) issued by NPA will be free; however, each replacement card costs $10.

Members should identify themselves as Quality Care Health Plan members at the pharmacy so their claims can be submitted electronically. If a paper claim form is needed, members should call NPA at (800) 250-9594 and a form will be mailed to them.

Claims should be submitted to:
NPA, Group Number 1400
711 Ridgevale Ave.
East Hanover, NJ 07936

The co-pay ($6 for generic medicines and $12 for brand names) applies to each 30-day supply. Reimbursement for out-of-network prescription purchases will be limited to the network price less the applicable copayment. When a generic drug is available but a brand name is purchased for any reason, the member must pay the difference in cost between the brand-name drug and the generic drug plus the generic copayment of $6.

Mental health claims
Magellan Behavioral Health is the mental health and substance abuse administrator for QCHP. To qualify for the highest level of benefits with the lowest out-of-pocket costs, members must call (800) 513-2611 to receive pre-approval and a referral to a network provider. Additional details about the mental health and substance abuse benefits are included in the State of Illinois Benefits Handbook and in the Member Assistance Program Employee Information Guide, which is available from the Benefits Center.

Claims appeal process
Information about the claims appeal process for QCHP is provided on Page 35 of the Benefits Handbook.

Usual and Customary (U&C)
For network Preferred Provider Organization (PPO) charges, Usual and Customary (U&C) is an amount determined by the plan administrator according to the negotiated schedule for that provider or product.

For non-network or non-preferred provider charges, (U&C) is an amount determined by the plan administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition.

If the charges exceed usual and customary, you are responsible for the portion of the expense that is above the usual and customary. Amounts in excess of usual and customary are not eligible charges and are not applicable to annual plan deductible or out-of-pocket maximum.

IMPORTANT: The percentage of the claim that will be paid is always based on the usual and customary charge or the actual charge made by the provider, whichever is less.

PPO hospital reduces your cost
Preferred Provider Organization (PPO) hospitals are those that the state has contracted to provide services at a negotiated rate. In Champaign-Urbana, both Carle and Provena Covenant are PPO hospitals. There are also PPO hospitals in most areas of the state, including facilities for inpatient treatment of alcoholism and substance abuse and transplant PPO facilities serving the state of Illinois. A complete list of facilities is included in the Benefits Choice Options booklet. All stays in a PPO facility must be precertified.

Health Maintenance Organizations (HMOs)

HMOs and emergencies
A good rule of thumb is always to call your HMO before seeking emergency medical care, either in or outside your HMO’s service area. If the emergency occurs in your HMO area and you are able, you should first try to contact your primary-care physician for instructions. If the emergency is after hours or you are out of the area, you should call the number provided on all HMO identification cards for that purpose. If the emergency is such that you are unable to call first, call as soon as possible after treatment is received. Making that call should eliminate the risk of claim problems when your HMO is asked to pay emergency charges.

Remember that the only out-of-area benefits available under an HMO are for emergency treatment or for non-emergencies when a referral has been issued by the HMO. This restriction is particularly important when you are traveling for extended periods or you have a dependent who is away, such as a child away at school. For more information about how your HMO defines an emergency and what is required if you have an out-of-area emergency, contact your HMO.

HMO claims appeals process
Most HMO problems can be resolved on an informal basis through the primary-care physician, or clinic or hospital administration personnel. However, if you feel a problem has not been resolved satisfactorily, there are additional appeal steps that can be used. Each HMO has its own three- to four-step complaint or grievance procedure that is detailed in the certificate provided to its members. Typically, at the highest appeal level the complaint states his/her case before a committee made up of other HMO members. The decision of that committee is binding upon the HMO.

If there is still not a satisfactory resolution, a complaint may be filed with the Illinois Department of Insurance and finally with the Group Insurance Division of Central Management Services. “Final” appeal information is included in the Member Benefits Handbook.

Remember to precertify all inpatient and surgical care and save $400. Call (800) 327-7443.

The advantages of using a PPO hospital:
• $100 hospital admission deductible is waived.
• Patient copayment is limited to 10 percent of eligible charges.

If the employee resides within 25 miles of a PPO hospital but chooses another hospital, the $100 deductible applies and the copayment increases to 35 percent. If there is no PPO hospital within 25 miles, the deductible still applies but the copayment is limited to 20 percent.

Out-of-pocket maximums
The separate non-PPO maximums are intended as an added incentive to avoid use of non-PPO facilities.

When an employee chooses a non-PPO facility, his/her out-of-pocket maximum for deductibles and copays can be as much as $3,800 in eligible expenses; use of a PPO hospital limits the out-of-pocket maximum to $800 in eligible expenses (except for prescription drug or mental health or substance abuse service copayments which cannot be applied toward the out-of-pocket maximums). A summary of expenses that will apply toward the general and non-PPO out-of-pocket maximums:

What does ‘family cap’ mean?
Once the combined deductibles paid for your family members total the cap amount, no other family member need meet a deductible. For example, if your salary is $49,800 or less, and three family members satisfy their deductibles, the fourth will not have to satisfy a deductible before benefits can be paid. A family cap of $300 does not mean that you must accumulate $300 in deductibles before any benefits can be paid; if one dependent satisfies his/her deductible, that dependent’s expenses will be paid without regard to a deductible. ■
## Comparison of Health Plans

### Quality Care Health Plan (administered by UNICARE)

<table>
<thead>
<tr>
<th>Benefits payable subject to usual and customary (U&amp;C) limitations. Consult Member Benefits Handbook, Pages 37 to 63, for complete benefits information.</th>
<th>HMO plans These are the minimum benefits HMOs provide; consult HMO certificate for complete information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General deductibles</strong></td>
<td><strong>Inpatient hospital services</strong></td>
</tr>
<tr>
<td>$100 per non-PPO hospital admission</td>
<td>PP/hospital* 90 percent, no deductible</td>
</tr>
<tr>
<td>$100 per emergency room</td>
<td>PPO/hospital* 90 percent, no deductible</td>
</tr>
<tr>
<td>Annual-plan deductible for all other charges</td>
<td>* See complete list of participating hospitals in the Benefit Choice Options Booklet, Pages 26-29.</td>
</tr>
<tr>
<td>(e.g., professional charges):</td>
<td>Non-PPO/hospital 65 percent after deductible if member resides within 25 miles of PPO. Increases annual out-of-pocket maximum.</td>
</tr>
<tr>
<td><strong>Employee</strong></td>
<td>80 percent after deductible if member does not reside within 25 miles of PPO.</td>
</tr>
<tr>
<td>Annual salary</td>
<td>80 percent after deductible if member does not reside within 25 miles of PPO.</td>
</tr>
<tr>
<td>Deductible</td>
<td>Note: All inpatient hospital confinements, including pregnancy/maternity, must be precertified to be eligible for full benefits. See below.</td>
</tr>
<tr>
<td>Family Cap</td>
<td><strong>Mandatory precertification</strong></td>
</tr>
<tr>
<td>$150</td>
<td>Pre-certification of elective hospital admissions (including pregnancy) and surgery (including outpatient) is required. Emergency admissions require that certification be obtained within 2 business days of admission. Failure to obtain precertification will result in a $400 penalty. Call precertification unit at (800) 327-7443.</td>
</tr>
<tr>
<td>$300</td>
<td>Hospital utilization admission review and surgery requirements vary. Consult specific HMO for details.</td>
</tr>
<tr>
<td><strong>Semi-private room, board, and nursing and ancillary services</strong></td>
<td><strong>Second surgical opinion</strong></td>
</tr>
<tr>
<td>80 percent</td>
<td>100 percent, no deductible. Precertification will advise if second surgical opinion necessary.</td>
</tr>
<tr>
<td><strong>Physician and surgeon charges</strong></td>
<td>Benefits vary by HMO. Consult specific HMO for details.</td>
</tr>
<tr>
<td>80 percent after annual plan deductible</td>
<td><strong>Durable medical equipment, prosthetic devices</strong></td>
</tr>
<tr>
<td>* Note: Surgery (including pregnancy) requires precertification. Call (800) 327-7443.</td>
<td>80 percent after annual plan deductible</td>
</tr>
<tr>
<td>100 percent, $10 copayment per outpatient physician visit may apply</td>
<td>Prosthetic devices: 80 percent</td>
</tr>
<tr>
<td><strong>Outpatient diagnostic lab and X-ray</strong></td>
<td>100 percent Consult specific HMO for limits</td>
</tr>
<tr>
<td>100 percent after annual plan deductible</td>
<td><strong>Physician and surgeon charges</strong></td>
</tr>
<tr>
<td>80 percent</td>
<td><strong>Physician and surgeon charges</strong></td>
</tr>
<tr>
<td>Children through age 6, 80 percent, no deductible;</td>
<td>80 percent after annual plan deductible</td>
</tr>
<tr>
<td>Children entering grades 5 and 9, 80 percent, no deductible;</td>
<td>* Note: Surgery (including pregnancy) requires precertification. Call (800) 327-7443.</td>
</tr>
<tr>
<td>Adults over age 18, 80 percent, no deductible, to $175 (combined physician/lab maximum)</td>
<td>100 percent, $10 copayment per outpatient physician visit may apply</td>
</tr>
<tr>
<td>$10 copayment per visit may apply, then 100 percent</td>
<td><strong>Maximum out-of-pocket expense</strong></td>
</tr>
<tr>
<td>100 percent</td>
<td>After combined deductibles and copayments for eligible expenses equal $800 per individual per contract year or $2,000 per family per contract year, plan pays 100 percent of covered expenses for the remainder of the contract year. Use of non-PPO/hospital will result in added out-of-pocket costs up to $3,000 per individual, $7,000 per family.</td>
</tr>
<tr>
<td><strong>Annual maximums</strong></td>
<td>150 percent of total annual premium (combined member and state payments)</td>
</tr>
<tr>
<td>Unlimited</td>
<td><strong>Lifetime maximums</strong></td>
</tr>
<tr>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Free-standing benefits</strong></td>
<td><strong>Comparison of Health Plans</strong></td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td><strong>Quality Care Health Plan (administered by UNICARE)</strong></td>
</tr>
<tr>
<td>Administrator: National Prescription Administrators (NPA)</td>
<td>Benefits payable subject to usual and customary (U&amp;C) limitations. Consult Member Benefits Handbook, Pages 37 to 63, for complete benefits information.</td>
</tr>
<tr>
<td>In-network, copay for 30-day supply</td>
<td><strong>HMO plans</strong> These are the minimum benefits HMOs provide; consult HMO certificate for complete information</td>
</tr>
<tr>
<td>$6 copayment for a generic drug</td>
<td><strong>Inpatient hospital services</strong></td>
</tr>
<tr>
<td>$12 copayment for name-brand drug with no generic equivalent</td>
<td>PP/hospital* 90 percent, no deductible</td>
</tr>
<tr>
<td>$6 plus difference between cost of name brand and generic if employee requests name brand when generic is available</td>
<td>* See complete list of participating hospitals in the Benefit Choice Options Booklet, Pages 26-29.</td>
</tr>
<tr>
<td><strong>Psychiatric care and alcohol- and substance-abuse care</strong></td>
<td>Non-PPO/hospital 65 percent after deductible if member resides within 25 miles of PPO. Increases annual out-of-pocket maximum.</td>
</tr>
<tr>
<td>Administrator: Magellan Behavioral Health (800) 513-2611 for referral</td>
<td><strong>Second surgical opinion</strong></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100 percent, no deductible. Precertification will advise if second surgical opinion necessary.</td>
</tr>
<tr>
<td>In-network: $50 per day copayment up to $275 per admission then 100 percent</td>
<td>Benefits vary by HMO. Consult specific HMO for details.</td>
</tr>
<tr>
<td>Out-of-network: $50 per day copayment up to $250 per admission then 60 percent</td>
<td><strong>Maximum out-of-pocket expense</strong></td>
</tr>
<tr>
<td>Partial Hospitalization/Intensive Outpatient</td>
<td>After combined deductibles and copayments for eligible expenses equal $800 per individual per contract year or $2,000 per family per contract year, plan pays 100 percent of covered expenses for the remainder of the contract year. Use of non-PPO/hospital will result in added out-of-pocket costs up to $3,000 per individual, $7,000 per family.</td>
</tr>
<tr>
<td>In-network: $25 per day copayment up to $125 per admission then 100 percent</td>
<td>150 percent of total annual premium (combined member and state payments)</td>
</tr>
<tr>
<td>Out-of-network: $25 per day copayment up to $125 per admission then 60 percent</td>
<td><strong>Annual maximums</strong></td>
</tr>
<tr>
<td>Outpatient: If referral (in-network) through Member Assistance Program</td>
<td>Unlimited</td>
</tr>
<tr>
<td>$15 copayment per visit</td>
<td>Unlimited</td>
</tr>
<tr>
<td>If no referral (out-of-network)</td>
<td><strong>Free-standing benefits</strong></td>
</tr>
<tr>
<td>Psychiatric care benefit will be 50 percent of charge, but not more than $35 per visit and no more than $50 visits per year; providers limited to licensed clinical social worker, psychologist or psychiatrist</td>
<td><strong>Comparison of Health Plans</strong></td>
</tr>
</tbody>
</table>

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History of Health Care Reform

The health care system in the United States is undergoing significant changes as a result of recent legislation and other initiatives aimed at improving access to care, controlling costs, and enhancing quality. These reforms seek to address long-standing issues such as rising premiums, out-of-pocket expenses, and the need for greater transparency in the health care marketplace. The table above provides a comparison of benefits offered by the Quality Care Health Plan and various HMOs. It highlights differences in deductibles, copayments, and coverage limits for various services, illustrating the potential variability in benefits across different plans.

Inpatient hospital services include medical and surgical care provided in a hospital setting. The benefits are extensive, covering a wide range of services from basic room and board to complex medical procedures. Outpatient services, on the other hand, focus on care provided outside of a hospital environment, including physician visits, lab tests, and imaging procedures. These services are often more routine and preventive in nature.

Physician and surgeon charges are another critical component of health care benefits. These costs can vary significantly depending on the type of service provided, the level of care required, and whether the provider is in-network or out-of-network. The table outlines copayments and deductible levels for in-network and out-of-network services, reflecting the benefits-sharing arrangements between the plan and providers.

Durable medical equipment and prosthetic devices are also an area of concern, especially for individuals with long-term needs or disabilities. The coverage for these items is designed to support independent living and function, and the table shows the level of coverage provided by the plan for such expenses.

The maximum out-of-pocket expense is a crucial consideration for individuals planning for their health care needs. This limit caps the total cost sharing for beneficiaries during a contracted period, ensuring that expenses do not exceed a predetermined amount.

Annual and lifetime maximums are important limits on annual and cumulative benefits, respectively. These caps help to manage costs and ensure that beneficiaries are protected from incurring excessive financial burdens.

The free-standing benefits section includes prescription drugs and psychiatric care, among others. These services are covered on a separate basis, with specific copayments and deductibles that may apply.

Understanding the details of health care benefits is essential for making informed decisions about health insurance. The table provides a comprehensive overview of the coverage provided by the Quality Care Health Plan and various HMOs, allowing individuals to compare and select the plan that best meets their needs.
Have you given any thought to how much your retirement income might be? It is believed you need 60 to 80 percent of your preretirement income as retirement income. Many people are not with a single employer long enough to accumulate a pension at that level, so having personal savings to supplement any pension and/or Social Security benefits becomes very important. Tax-deferred retirement plans can help build your retirement savings — and save current income taxes, too.

The advantages of starting early
While it is never too late to start saving for retirement, there are strong advantages to starting early, even if you find you have to stop after a few years. Below is an example. Employee #1 started at age 30 but stopped after 10 years; Employee #2 began at age 45 and continued to age 65. The example uses monthly contributions of $100 and an annual growth/interest rate of 8 percent.

<table>
<thead>
<tr>
<th>Start Age</th>
<th>Stop Age</th>
<th>Total Contributions at Age 65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee #1</td>
<td>30 45</td>
<td>$12,000 $133,399</td>
</tr>
<tr>
<td>Employee #2</td>
<td>45 65</td>
<td>$24,000 $58,902</td>
</tr>
</tbody>
</table>

The person who only contributed for 10 years has $74,497 more at age 65 than the one starting at 45 and contributing for 20 years. This reflects the value of time and compounding of an investment. If the 30-year-old had continued to save at the same rate until age 65, the accumulation is even more dramatic — $229,388. It would take the employee starting at age 45 $685 per month to accumulate that same amount by age 65.

Save current income tax
In addition to future benefits, tax-deferred plans provide current tax saving through the use of tax-deferred investing by payroll deduction. The table above shows the tax savings realized at two salary levels. Each assumes zero exemptions claimed for tax purposes. Note that take-home pay actually doesn’t go down by the $100 invested. Consequently many people find they can afford to save more than they anticipated.

Two tax-deferred saving plans
- University’s tax-deferred retirement program (TDRP), under section 403(b) of the IRS Code, includes investment opportunities with two mutual fund families (Fidelity and American Century) and three insurance companies (TIAA-CREF, Aetna and Met Life).
- State’s deferred compensation program, under Section 457 of the IRS Code, includes a guaranteed interest account and several individual mutual funds.

Are you saving for retirement?

<table>
<thead>
<tr>
<th>Tax savings with tax-deferred retirement plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Salary</td>
</tr>
<tr>
<td>Monthly Salary</td>
</tr>
<tr>
<td>Minus SURS &amp; Insurance</td>
</tr>
<tr>
<td>Taxable salary before TDRP</td>
</tr>
<tr>
<td>Minus amount deferred</td>
</tr>
<tr>
<td>Minus federal &amp; state tax</td>
</tr>
<tr>
<td>Take-home pay</td>
</tr>
<tr>
<td>Take-home pay reduction</td>
</tr>
<tr>
<td>Tax savings per pay</td>
</tr>
<tr>
<td>Annual tax-deferred amount</td>
</tr>
<tr>
<td>Annual tax savings</td>
</tr>
</tbody>
</table>

Enroll any time during the year
Enrollment is not limited to the Benefit Choice period. Contributions are by payroll deduction only and you determine the amount you want to save.

The minimum under the university’s TDRP is 1 percent of your salary reduced by your retirement system contribution. The plan state minimum is $20 per month.

The maximum that can be contributed to the university’s TDRP is generally 25 percent of your salary reduced by your retirement system contribution, but not more than $10,000 per calendar year. Contributions are made to the State Deferred Compensation Plan, or both the 403(b) and 457 plans in a calendar year, the annual maximum is limited to 25 percent of taxable salary but not more than $8,000.

To begin making contributions …
1) Contact the Benefits Center to obtain a current TDRP information packet.
2) Contact the company to obtain an enrollment application packet:
   ✓ Aetna, (800) 627-1590
   ✓ American Century, (800) 345-3533, Ext. 4999
   ✓ Fidelity, (800) 343-0860
   ✓ Met Life, (800) 867-7167
   ✓ TIAA-CREF, (800) 842-2005
3) Return the application to the Benefits Center and complete a salary reduction agreement.

Where to go for help
The Benefits Center
807 S. Wright St., Suite 480
Illini Union Bookstore Building, corner of W right and Daniel streets. Enter through northeast doors.
Office hours
Walk-in 8:30 a.m. to 5 p.m.
Appointments are recommended to see a counselor
Telephone 8:30 a.m. to 5 p.m.
General benefits information
Telephone 333-3111
E-mail benefits@uillinois.edu
Web site http://webster.uflir.uiuc.edu/benefits
To order claim or other forms
Press 1 – you may leave a message after hours
Fax 244-5604
Benefits O n Call (See article p. 5)
265-UBIC (8422)
To reach your counselor by phone or e-mail (Last names beginning with w)
A-E Brenda Butts 244-1053
F-K Judy VanDeventer b-butts1@uillinois.edu
L-Q Patricia Kirby 244-1045 jvandeve@uillinois.edu
R-Z Michael Ward p-kirby1@uillinois.edu
mhward@uillinois.edu
Assistant Manager for Services
Norma Kite 244-1042 n-kite@uillinois.edu
Benefits Center Director
James P. Davito 244-1041 jdvito@uillinois.edu

Life Insurance

Optional plans
In addition to the employer-provided life insurance equal to 100 percent of your annual salary, you may purchase optional life insurance for yourself, your spouse and children under the state plan, subject to evidence of good health and insurance company approval. Health certificates are available from the Benefits Center and must be completed and returned by May 31. Accidental death and dismemberment insurance, which does not require evidence of good health, also is available.

- State Plan Optional Life – 1, 2, 3 or 4 times annual contract salary.
- State Plan Accident and Dismemberment Life Insurance – 2, 3 or 4 times annual contract salary.
- Dependent Child Life Insurance – $5,000 per child.

Cost is $0.26 per month, regardless of age.

Who are your beneficiaries?
If there has been a change in your life — such as a marriage, divorce, death in the family, etc., you should review your beneficiary designations on your life insurance. You may call to request copies of the latest designations you have on file to be mailed to you. Or you may stop by the Benefits Center and look at your designations. You will have designated a beneficiary for the employer-provided state life insurance, which is equal to your annual salary. You also may have designations for accidental death and dismemberment insurance and tax-deferred annuity contributions. Changes in any of your beneficiary designations can be made at any time.

Remember that you also have a beneficiary designation on file at the State Universities Retirement System (SURS). The latest designation on file with the SURS Personal Benefits Summary Statement distributed to employees in the fall every year or you can request a copy by calling SURS at 378-8800. The form required to change your SURS beneficiary can be obtained from either SURS or the Benefits Center.
Vision care plan

The Vision Care Plan is provided to employees at no cost and automatically includes all employees and their dependents who are insured under one of the state health plans. It also extends to persons on disability, to retirees and to survivors.

Under the plan, which is administered by Vision Service Plan (VSP), employees and insured dependents are eligible for a standard eye exam and glasses once each 24 months. The plan benefits include:
- $10 patient copayment for an eye exam.
- $10 patient copayment for spectacle lenses, single or multifocal, glass or plastic (special options such as progressive, photochromic, tinted, etc., lenses can be purchased at an additional charge).
- $10 patient copayment for frames chosen from a selection of frames covered in full under the plan. (Frames not in the selection can be purchased at an additional charge).
- $50 patient copayment for elective contact lenses; hard or soft daily-wear lenses or rigid gas-permeable lenses. The contact lens benefits payable for non-participating providers and for extended wear or disposable contact lenses is $70.

The most comprehensive benefits are provided when services are received from plan member doctors; however, benefits also are available for services received from non-member doctors. For a complete list of member doctors, call VSP at (800) 877-7195 or visit its Web site at www.vsp.com. When you go to a member doctor, you simply pay your copay amount and there is no paperwork. If you choose to go to a non-member doctor, for reimbursement from VSP, you must mail a copy of your bill to Vision Service Plan.

Previous users of VSP may receive repeat services on or after the first day of the 24th month following the initial service.

Flexible spending accounts

Do you have out-of-pocket medical or child-care expenses greater than $240 per year? You can save money by eliminating the tax you pay on the dollars used to pay these expenses by participating in the Medical Care Assistance Plan (MCAP) for medical expenses or the Dependent Care Assistance Plan (DCAP) for child-care expenses. The plans deduct from your paycheck – before tax is calculated – a minimum of $20 up to a maximum of $416.66 per month ($5,000 per year) that is deposited into an account that is reimbursed with your untaxed dollars.

Dental coverage is automatic for all employees (and dependents as long as they are enrolled in one of the health plans). The employee and dependents must be on the same dental plan. Employees cannot enroll in the dental plan and waive the health plan or vice versa.

Benefits information by phone

Call Benefits On Call at 265-UIBC

Now you have an alternative to calling a benefits counselor if you want to verify your health plan enrollment or need to know how much life insurance you have. This information and much more is available by calling Benefits On Call almost any time, including evenings and weekends. The only time Benefits On Call is not available is 4 to 6 a.m. Monday through Saturday and 10 p.m. Saturday to 8 a.m. Sunday. All you need is a push-button telephone.

With Benefits On Call you can:
- Request a personalized Benefits Statement be faxed or mailed to you.
- Request claim forms and other forms be faxed or mailed to you.
- Listen to confirmation of all health and dental plan enrollments as well as how many dependents, if any, are insured.
- Find out amounts of insurance coverage under the state term life plan and accidental death and dismemberment plans.
- Get confirmation of tax-deferred retirement plan and flexible spending account enrollment as well as the percent of salary or dollar amount you authorized to be deducted monthly.
- Get answers to many benefits-related questions, such as when changing plans is allowed, when dependents can be added and how long they are eligible, etc.

How to use Benefits On Call

Using a push-button phone, press 265-UIBC (8422), or 5-8422 from a university phone. You will hear a welcome message and be asked to enter your Social Security number followed by the # key.

Next you will be asked to enter a four-digit personal identification number (PIN) that you can then change to a PIN of your choice to secure your record. That new PIN will be required for all future calls to Benefits On Call.

The system will then give a menu of topics that can be accessed by pressing the appropriate number on the telephone keypad.

Once you become familiar with the system, you will be able to take shortcuts from the main menu by pressing the series of numbers given in the table below.

Comparison of dental plans

Both the Quality Care Dental Plan and the CompDent of Illinois managed care dental plan are administered by CompDent and any inquiries regarding claims, managed care participating dentists, etc., should be directed to (800) 999-1669.

Dental coverage is automatic for all employees (and dependents as long as they are enrolled in one of the health plans). The employee and dependents must be on the same dental plan. Employees cannot enroll in the dental plan and waive the health plan or vice versa.

Benefits On Call

To bypass interim menus and go directly to an area of interest, press the numbers of a topic below at any time during the Main Menu.

Benefits Statement or Forms
- Benefits Statement or Forms mailed ........................................ 21
- Benefits statement mailed .................................................. 22
- Forms faxed .................................................. 31
- Forms mailed .................................................. 32
- Health insurance:
  - Health plan enrollment ........................................... 111
  - Changing plans .................................................. 411
  - Adding dependent ................................................. 412
  - Current dependent coverage ..................................... 413
  - Filing claims .................................................. 4151
- Dental insurance:
  - Enrollment .................................................. 112
  - Changing plans .................................................. 411
  - Filing claims .................................................. 4152

Shortcuts from Main Menu

To bypass interim menus and go directly to an area of interest, press the numbers of a topic below at any time during the Main Menu.

Benefits on Call provides information only; you may not change any of your benefits using this service.
When to contact the Benefits Center
- Change in your home address
- Change in marital status
- Expect or have a new baby (if you want the child insured)
- An insured child marries or otherwise becomes eligible as an independent

While on leave from the university... If you are on a disability, family or seasonal leave, etc., the Benefits Center will send a monthly bill to your home for any insurance premiums that are normally deducted from your paycheck. To avoid cancellation of your insurance, please remember the following:
1. Keep your home address current to ensure that your bill is sent to the correct address. If your address changes, use NESSIE to update your current address (http://nessie.umn.edu).
2. Pay your bill by the due date.
3. If you have questions, please call your benefits counselor or the person listed on the bill.

If your coverage is terminated because a bill was not paid, re-enrollment is possible only when you return to work and re-enrollment in some optional plans is not guaranteed. For example, re-enrollment for optional life insurance is subject to evidence of good health and insurance company approval.

Enrolling newborn children
While enrollment of a newborn child in the health plan is guaranteed (provided the request is made within 60 days of birth), it is never automatic. You must take an action to add them to your policy, even if you already have other insured dependents. You can either use NESSIE or contact the Benefits Center for necessary forms. Notifying your HMO office, obtaining precertification for delivery through the Quality Care Health Plan, or filing claims for delivery expenses do not result in a notice of birth to the Benefits Center. If you fail to notify the Benefits Center within 10 days of birth, the employer bears all costs of delivering the child.

Rules for adding dependents
Federal legislation called the Health Insurance Portability and Accountability Act (HIPAA) allows you to add dependents to your health plan without showing evidence of good health and without insurance company approval.

Eligible dependents are defined as a legal spouse, children younger than 19 or children who are full-time students up to age 23. Enrollment must be requested by May 31 and coverage will be effective July 1. After Benefits Choice, dependents not added at employment, marriage or birth can be added without evidence of good health within 60 days following a change in family status such as a spouse’s loss of insurance coverage.

HIPAA also affects the applicability of pre-existing condition limitations if an individual being added to the plan has “creditable coverage.” A pre-existing condition is defined as any condition for which an individual has received treatment or taken prescribed medications within the three months prior to the effective date under the plan. Then there are no benefits or limited benefits (depending upon the plan chosen) payable for that condition for the first six months of coverage. “Creditable coverage” is defined as any group or individual health coverage in effect for an individual within 63 days of becoming insured under the university health plan. What this means is that the six month pre-existing condition limitation will be reduced by the time period the individual was insured under another plan before the university plan’s effective date. Two examples:

- A new employee comes to the university within 63 days of leaving another employer and has had continuous health insurance for the past year. That previous year of coverage completely eliminates any pre-existing condition limitation under university plans.
- A new employee who has been insured by another plan for the past four months would be subject to the pre-existing condition limitation for only two months—the six months pre-existing period is reduced by the four months of previous coverage.

The same examples apply to dependents added at employment, during a later Benefit Choice or following a change in family status.

Recertify dependents in August The state requires yearly recertification of dependents age 19 or older enrolled as students, handicapped or under the “other” category. Annual recertifications were previously processed during the Benefit Choice period. However, beginning July 1, 1998, the recertification period was changed to the month of August. Members requiring recertification will receive a notification letter in July.

Eligible dependent children (19+)
Student: Enrolled as a full-time student (as defined by the school) at an accredited school. This dependent must be financially dependent upon the employee and eligible to be claimed as a dependent for Illinois state income tax purposes.
Handicapped: Continuously disabled from a cause originating prior to age 19, financially dependent upon the employee and eligible to be claimed as a dependent for Illinois state income tax purposes.
Other: The dependent must have been enrolled in the state health plan continuously since before Feb. 11, 1983. In this case, the dependent need not be a student but must be continuously disabled as a dependent for Illinois state income tax purposes.

Other dependent health insurance is not available to persons in this category. If the dependent does not qualify under any of these options, you must notify the Benefits Center so coverage can be terminated and the dependent can be offered the option of continuing the coverage at their own expense under the federal legislation known as COBRA, which allows for up to 36 months of continued coverage.

Benefits for part-time employees
Persons with appointments between 50 and 99 percent are eligible to participate in the group insurance plans. However, those electing to waive participation in all or some plans must be eligible—within 10 days of their initial date of employment – to participate in all or some of the insurance plans provided at the university. To participate, the employee must complete the application form for the appropriate health plan.

During open enrollment, you are required to pay a share of the normally employer-paid premiums proportionate to the employee’s percentage of time on campus. The following minimum amounts are required:
- Legal spouse
- Unmarried child age 19 to 23 who is a full-time student in an accredited school and is financially dependent upon the employee
- Child 24 and older who is an insured dependent

Other dependents – the Benefits Center is notified of change in family status when the employee is terminated.

Changing health plans? Pre-existing conditions covered immediately
If you have been employed by the university for at least six months, the pre-existing condition limitation will not apply when you are simply switching plans. This means that if you or an insured family member were enrolled for a health condition, covered expenses incurred due to that condition will be eligible for benefits beginning on the first day of coverage under the new plan.

Continuing coverage under ‘CO BRA’ Under the Consolidated Omnibus Budget Reconciliation Act, commonly called the “COBRA option,” coverage can be continued:
- For up to 18 months for employee and insured dependents – the Benefits Center is notified of employment terminations (other than retirement) by the appropriate human resources office.
- For up to 36 months by a divorced spouse or ineligible child—it is the employee’s responsibility to notify the Benefits Center within 60 days of a dependent becoming ineligible. Children become ineligible when they marry regardless of age, when they reach age 19, or age 23 if a full-time student.

The Benefits Center then notifies the state’s Department of Central Management Services (CMS). That office sends details about the cost and length of continuation available to the current address on file for the employee. If election and enrollment information is received, it is very important to notify the Benefits Center if it should be sent to an address other than the home address currently on file.

Continuation of coverage is guaranteed provided it is elected within 60 days from the date the election form is received. If elected, coverage and premium due will be retroactive to the date of coverage termination. More information about the continuation option can be found in the Member Benefits Handbook. Rates for continuation coverage can be obtained from the Benefits Center.

Who’s eligible for benefits?
For employees, the criteria for eligibility are as follows:
- Permanent appointment of 50 percent or more
- Temporary appointment of 50 percent or more for at least nine continuous months
- Eligible to participate in the State Universities Retirement System

The Illinois State Employees Group Insurance Act requires that all eligible full-time employees be enrolled in the health, dental, and vision insurance plans. Part-time (50 to 99 percent) employees may elect to waive all coverages, enroll for health, dental and vision only, life only, or both. Enrolled part-time employees are required to pay a share of the normally employer-paid premiums proportionate to their appointment time.

The Group Insurance Act also defines eligible dependents as:
- Legal spouse
- Unmarried child from birth to age 19, including a natural or adopted child or a stepchild, who lives with the employee in a parent-child relationship
- Unmarried child age 19-23 who is a full-time student in an accredited school and is financially dependent upon the employee
- Unmarried child age 19 and older who has been continuously mentally or physically handicapped with the cause originating prior to age 19 and is financially dependent upon the employee
- Non-student child age 19 and older who has been continuously enrolled as a dependent prior to Feb. 11, 1983, and continues to be financially dependent upon the employee

Dependents not added to the plan when they first become eligible—within 10 days of an employee’s first day of work—may only apply during the annual benefit choice enrollment period or within 60 days of a marriage, birth, adoption or some other qualified change in family status.

(See Benefits Briefs, page 7)
Benefits briefs

(Continued from page 6)

Make your change by phone (877) 819-5111

Again this year you have the option to change your health or dental plan by phone. CMS’ telephone enrollment system can be used until midnight, May 31 – 24 hours a day, seven days a week, from anywhere in the continental United States.

Some restrictions apply. For example, employees with dependent coverage will be able to use the telephone enrollment system only if their dependents’ Social Security numbers are already included in their insurance record. The telephone enrollment system also cannot be used to add dependents for coverage.

Through self-service, you are restricted in changing your enrollment by phone, be sure to read Pages 4 – 9 of the Benefit Choice Options booklet. There you will find complete instructions and a worksheet that helps ensure you have all the information required prior to calling.

Please note that when you use the system to make a change, your new elections are not complete until you hear “Your change (election) has been recorded.” You can call back immediately and hear that your change has been recorded by the telephone enrollment system. CMS will send a verification of your change to your home address.

Want to quit smoking?

Members and their dependents are eligible to receive up to a $50 rebate toward the cost of an approved smoking cessation program. This rebate is limited to one per year and is only available upon completion of the smoking cessation program. Hypnosis (performed by a professional other than a medical doctor) and acupuncture are not eligible under this program.

To receive reimbursement, you must submit:
- Receipt of payment for the program.
- Program certificate verifying the number of sessions and completion of the program.
- Member’s name, Social Security number, and telephone number

Send the information to:

Smoking Cessation Program
CMS/Group Insurance Division
Room 600, Stratton Office Building
Springfield, IL 62706

Adoption benefit program

Recognizing adoption as a meaningful and viable way to build a family, the state of Illinois has implemented an Adoption Benefit Program to assist state employees who adopt a child. To encourage adoption, especially among employees who adopt a child. To encourage adoption, especially among employees who adopt a child.

The program pays
- $150,000 Total life insurance (basic $50,000 plus $100,000 optional)
- $50,000 Less tax-free coverage

Faculty and staff assistance program

The Faculty and Staff Assistance Program confiden-

antly assists employees with personal problems. An employee assistance professional will assess the situation, refer employees to the appropriate resources and offer follow-up and assistance.

One of the best features for employees making Benefit Choice changes using NESSIE is that once

they have made a change, they will receive instant verification and documentation of the change via their UI e-mail address.

Additionally, employees can make their changes from their home, office or anywhere they access the Internet – both during and outside normal office hours.

To access NESSIE and the Benefit Choice application, go to http://nessie.uihr.uillinois.edu then go to the Benefits section. Follow the onscreen instructions to access the Benefit Choice form.

An overview session on using NESSIE for your Benefit Choice changes will be offered:

May 4: Illini Union Room 405:
- 10:11 a.m. and 11:30 a.m. -12:30 p.m.
- May 11: Illini Union Room 404: 2:3 p.m.

Awards and recognition

The Faculty and Staff Assistance Program is a big part of our commitment to faculty and staff members, retirees, dependents, all employees of allied agencies are eligible for the Benefit Choice form.

An overview session on using NESSIE for your Benefit Choice changes will be offered:

May 4: Illini Union Room 405:
- 10:11 a.m. – 1:2 p.m. and 2:30-3:30 p.m.

To register call 333-9065 or register online at http://nessie.uihr.uillinois.edu/sessions.html.

Although the Benefit Choice period formally ends on May 31, since it is a holiday, NESSIE may be used to make Benefit Choice changes until 10 p.m. Thursday, June 1. However, Benefits Center and NESSIE Help Desk employees will be available to provide assistance only until 5 p.m. on June 1.

The Advocate

(Continued from page 1)

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For a complete listing of these qualified family

status changes and special enrollment events, see Page

4 of the current state of Illinois Benefits Handbook.

*Premium for coverage above $50,000 is not tax-

exempt and coverage above that amount can be changed at any time.

Retirement options

(Continued from page 1)

If your paperwork is not submitted to SURS by the end of the election period, you will automatically and irrevocably default into the Traditional Benefit Plan.

Elective forms are available in the SURS “Choice Kit.” Forms should be completed and mailed to SURS as soon as you decide which retirement option is best for you. If you do not have an election form by the deadline, you will be enrolled in the Traditional Benefit Plan.

The Quality Care Health Plan premium for dependents continues to be “frozen” for this year. HMO rate changes up or down vary depending upon the HMO and whether coverage is for only one dependent or two or more dependents.

The share of premium based on salary that all employees are required to pay for their own health insurance will remain the same as last year’s. Salaries as of April 1 are used to determine the appropriate employee share but any change in that amount will not appear until the July payrolls.

Premiums for the Quality Care Dental Plan will remain the same for the new year and there will continue to be no premium charge to employees enrolled in the managed care dental plan.

Salary-based employee contributions for health plans:

- **July 1, 1998, to June 30, 1999**:
  - $24,400 or less: $15.00
  - $24,401 to $36,700: $20.00
  - $36,701 to $48,900: $22.50
  - $48,901 to $61,200: $25.00
  - $61,201 or more: $27.50

- **Effective July 1, 1999**:
  - $24,800 or less: $15.00
  - $24,801 to $37,400: $20.00
  - $37,401 to $49,800: $22.50
  - $49,801 to $62,300: $25.00
  - $62,301 or more: $27.50

*All the following dependent premium amounts exclude the “salary-based employee contributions” listed above. To calculate your total monthly premium, add the appropriate salary-based employee contribution amount to the dependent premium amount.

**Employee only**

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**One dependent**

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For more information, contact the following plan administrators. Plans and administrators may change, so watch for updates in the mail and check the Annual Benefit Choice Options booklet for the most current information.

**Quality care plans**

**Quality Care Health Plan**

Medical Plan Administrator: UNICARE
Group Number 28455, State of Illinois
P.O. Box 5025
Bolingbrook, IL 60440-5025
(888) 209-7950 (nationally)
TDD: (888) 209-7953

Medicare Precertification and Medical Case Management Administrator:
Intracorp
(800) 327-7443
TTY: (800) 855-2880 (National Relay Service)

Medical Assistance Program (MAP)

Mental Health and Substance Abuse Treatment Plan Administrator:
Magellan Behavioral Health
Group Number 28455
P.O. Box 909782
Chicago, IL 60690
(800) 513-2611
TDD: (800) 526-0848 (Illinois Relay Center)

Pharmacy Plan Administrator:
National Prescription Administrators Inc. (NPA), Group Number 1400
711 Ridgedale Ave.
East Hanover, NJ 07936
(800) 250-9594 (nationally)
TDD: (888) 269-5304

**Quality Care Dental Plan**

Indemnity Dental Plan Administrator:
CompDent Inc., Group Number 950
P.O. Box 4677
Chicago, IL 60680-4677
(800) 999-1669
TDD: (312) 829-1298

**HMOs**

**Health plans**

Health Alliance HMO
(800) 851-1379
TDD: (217) 337-8137

Personal Care
(800) 431-1211
TDD: (217) 366-5551

**Managed Care Dental Plan**

Managed Care Dental Plan Administrator:
Comp Dent of Illinois
P.O. Box 4677
Chicago, IL 60680-4677
(800) 999-1669
TDD: (312) 829-1298

**Vision plan**

Vision Plan Administrator:
Vision Service Plan (VSP)
Attention: Non-member claims
P.O. Box 997100
Sacramento, CA 95899-7100
(800) 877-7195
TDD: (800) 428-4833

**Flexible spending accounts**

FSA Program Administration:
FSA Unit
CMS/Group Insurance Division
Room 199, Stratton Office Building
Springfield, IL 62706
(800) 442-1300 or (217) 782-2548
TDD: (800) 526-0844

**Claims adjudication service**

Fringe Benefits Management Co. (FBMC), (800) 342-8017

**Life insurance, smoking cessation or adoption programs**

CMS/Group Insurance Division
Room 600, Stratton Office Building
Springfield, IL 62706
(800) 442-1300 or (217) 782-2548
TDD: (800) 526-0844

"Your Benefits" is printed annually for faculty and staff members of the University of Illinois at Urbana-Champaign. Every effort has been made to report the information included in this paper accurately. However, in the event of any discrepancy, the legal documents, policies or contracts pertaining to the various pay and benefits would prevail. This paper does not constitute such a legal document. Save this document for future reference.