University of Chicago

Medical Plans

Maroon Plan
HMO Illinois
University of Chicago Health Plan
Humana Premier HMO

Summary Plan Description

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Your Medical Benefits

The University of Chicago offers a choice of four medical plans. One is a preferred provider plan, and three are HMOs.

- The **Maroon Plan** is a preferred provider option (PPO). You choose the doctors and Hospitals you want to see for your medical care. The amount paid by the plan depends on the services you receive and the amount charged by the provider. When you choose providers in the network, you pay less. Unlike an HMO, you are covered, even if you get care outside the network. You can select from three levels of coverage: employee, double or family.
- The University also offers three HMO-style medical plans: HMO Illinois, Humana Premier and the University of Chicago Health Plan (UCHP). **HMOs** only provide in-network coverage. You select a Primary Care Physician who coordinates all of your medical care. If you go to a doctor or Hospital outside of your HMO without prior approval, you will not receive any benefits from the plan, except in an emergency. You can select from three levels of coverage: employee, double or family.

The chart below highlights the major differences in the way medical care is provided between the Maroon Plan and the HMOs.

	Maroon Plan **A Preferred Provider Option**	**HMOs**
Summary	• Gives you the maximum choice of doctors and Hospitals. • Focuses on treating illness and injury. • Has a higher premium than an HMO and you pay a higher share of the cost of care because you have a much wider choice of caregivers. • Provides discounts and pays more if you use providers who are part of the network.	• Limits your choice of doctors and Hospitals to only those who have contracted with the HMO to charge specific rates. • Reduces illness through wellness care such as physical exams. • Reduces unnecessary treatment by coordinating your care through your Primary Care Physician.
Intent	To provide true insurance for the cost of medically necessary treatment for illness and injury, while maintaining your freedom to choose providers.	To reduce medical care costs by keeping you healthy and to manage the costs that are incurred by monitoring your care and limiting your choice of providers.

Please review this summary and refer to your HMO documents for their terms of coverage for important details on plan limits and features.

If you have questions about your benefits, call the Benefits Office at 773-702-9634 or send an e-mail to benefits@uchicago.edu.

The capitalized terms in the Summary Plan Description have special meaning, which impacts your receipt of benefits under the plan. Please refer to the Glossary for the definition of those capitalized terms.

Participating in a Medical Plan

Eligibility

You are eligible for coverage under a medical plan if you are a:

- Full-Time Benefits-Eligible Employee of the University of Chicago (the "University").
- Part-Time Benefits-Eligible Employee of the University.

You can also cover your eligible Dependents, including your:

- Employee's legal spouse or university-registered same sex domestic partner ("DP")
- Unmarried child of employee or DP** up to age 26
- Unmarried military veteran dependent child of employee or DP up to age 30 if the child:
    - Has established residency in Illinois
    - Has served in the active or reserve components of the U.S. Armed Forces
    - Has received a release of discharge other than a dishonorable discharge
- Unmarried child beyond age 26 if the child is:
    - Incapable of self-sustaining employment due to a mental or physical disability that occurred before attaining age 26:
    - Dependent on employee/DP for support and maintenance; and
    - Covered continuously by the plan prior to and beyond age 26
- A child is a:
    - Natural child
    - Stepchild
    - Legally adopted child
    - Ward
    - Any individual named in a court order requiring coverage for a child (QMCSO)

    Who meets the following criteria:
        - Employee/DP has legal guardianship of child;
        - Child lives with employee/DP in parent/child relationship; and
        - Child provides no more than 50% of his/her own support

**If the domestic partnership terminates, a child of the DP would no longer be eligible for coverage under the plan.

You cannot provide coverage for your parents; grandchildren who do not meet the requirements listed above, or foster children.

Verification of relationship is required for any dependent being added to your coverage for the first time, or if you are adding a dependent again and have not provided documentation in the past. Documentation may include a marriage certificate or domestic partnership statement to add a new spouse or domestic partner. Documents for a new dependent child may include a birth certificate, adoption papers, or other appropriate legal documents may be provided. For military veteran dependents up to age 30 the "Certificate of Release or Discharge From Active Duty" document is also required. Return a copy of the required documents to the Benefits Office within 31 days of your date of hire as a Benefits-Eligible Employee.

If you and your spouse or Domestic Partner both work for the University, only one of you may cover your children as dependents.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO recognizes the rights of a child to coverage for health care benefits. Under a qualified child support order, the court can require you to provide coverage to a child under this plan.

You will be notified if any of your children are affected by a QMCSO. You may call the Benefits Office at 773-702-9634 for information regarding the procedures governing QMCSOs.

Enrolling

You may enroll in a medical plan:

- Within 31 days of your date of hire as a Benefits-Eligible Employee and if you complete and submit an enrollment form within that 31-day period. Your coverage takes effect as of such hire date.
- If you do not enroll within 31 days, you must wait until Open Enrollment, unless you have a qualifying change in status or special enrollment event. Enrollments made during Open Enrollment take effect as of the following January 1.

Enrollment materials are available online at http://hr.uchicago.edu or from the Benefits Office.

Coverage Levels

You can choose employee coverage or coverage for yourself and your Dependents:

- **Employee** covers you only.
- **Double** covers you plus one Dependent. For example, you could cover yourself and one child or yourself and your spouse or Domestic Partner.
- **Family** covers you, your spouse or Domestic Partner, and your Dependent Children.

If both you and your spouse or Domestic Partner are University employees, you may each select employee coverage or one of you may choose family coverage. Both of you cannot choose family coverage.

ID Cards

You will receive an ID card after you enroll.

Maroon Plan, you will receive an ID card for yourself and an additional card if you elect double or family coverage. Your card will include information on the network and utilization review services. You will also receive prescription ID cards from Caremark. You need to present this card at a participating pharmacy to have a prescription filled.

UCHP, you and each covered family member will receive an ID card plus a prescription drug card. You need to present your prescription drug card at a participating pharmacy to have a prescription filled.

Humana Premier HMO, you will receive one ID card for yourself and one for each covered family member. The card can also be used to fill prescriptions at participating pharmacies.

HMO Illinois, you will receive one ID card for yourself and one for each covered family member. The card can also be used to fill prescriptions at participating pharmacies.

Carry your ID card with you at all times. Use it when you visit your Primary Care Physician or other HMO provider. You will also use this card as identification at Hospital emergency rooms. You can request extra or replacement cards by contacting your medical plan.

Pre-Existing Conditions

None of the plans offered by the University have a pre-existing condition clause. This means if you have a medical condition prior to enrolling in a plan, the treatment for that medical condition is covered provided that the particular services are covered and plan provisions are followed.

Cost of Coverage

You pay a portion of the premium for medical coverage. The University pays the other portion. Your cost is based on:

- The plan you choose;
- The coverage level you choose (for example, employee or family);
- Your annual salary; and
- Whether you are a Full-Time employee or a Part-Time employee.

Your cost is automatically deducted from your paycheck before income taxes are withheld. The premium may be adjusted each year.

For a current list of premiums, visit our web site at http://hr.uchicago.edu or contact the Benefits Office.

When Coverage Begins

If you are eligible when you start working for the University, your and, if elected, your Dependent's coverage begins on your first day of work, as long as you return your enrollment form and Dependent's documentation to the Benefits Office within 31 days of your hire date.

If you become a Benefits-Eligible Employee during your employment with the University, your and, if elected, your Dependents' coverage begins on the date you become a Benefits-Eligible Employee, as long as you return your enrollment form and Dependent's documentation to the Benefits Office within 31 days of that date.

If you enroll during the annual Open Enrollment, your and, if elected, your Dependent's coverage begins on the following January 1 as long as you return your Dependent's documentation to the Benefits Office prior to the closing date of Open Enrollment.

Changing Your Elections

Generally, once you have elected a medical plan and coverage level, you cannot change your elections until Open Enrollment, unless you have a qualifying change in status or special enrollment event as explained below.

Qualifying Change in Status

A qualifying change in status includes:

- Marriage, divorce, legal separation or annulment.
- Registration or termination of a domestic partnership.

- Death of a child, spouse or Domestic Partner.
- Birth, adoption or placement for adoption of a child.
- The start or end of your spouse's or Domestic Partner's employment.
- A change in your, your spouse's or your Domestic Partner's employment status.
- Loss of status as a Dependent.
- Loss of or change in your spouse's or Domestic Partner's health care coverage.
- A court order which requires that a Dependent be covered under your medical coverage.

Please note, for any of the above provisions to apply to you and your Domestic Partner, your Domestic Partner must qualify as a Dependent under Internal Revenue Code Section 152.

Verification of relationship is required for any dependent being added for the first time to your coverage. Documentation may include a marriage certificate or domestic partnership statement to add a new spouse or domestic partner. Documents for a new dependent child may include a birth certificate or adoption papers, or other appropriate legal documents may be provided. Return a copy of the required documents to the Benefits Office within 31 days of the qualifying life event.

If you have a qualifying change in status, you must complete a change form **within 31 days** of the change. Any change in your elections must be consistent with the qualifying change in your circumstances.

Generally, the coverage due to a qualifying change in status starts on the first of the month following the receipt by the Benefits Office of the appropriate change form along with the Dependent Documentation. However, in case of birth or adoption of a child, the new coverage starts on the date of the event if the change form and Dependent Documentation were received within 31 days of the birth, adoption or placement for adoption.

Special Enrollment Event

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your Dependents in the medical plan provided you request enrollment within 31 days after your other medical coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Verification of relationship is required for any dependent being added for the first time to your coverage. Documentation may include a marriage certificate or domestic partnership statement to add a new spouse or domestic partner. Documents for a new dependent child may include a birth certificate or adoption papers, or other appropriate legal documents may be provided. Return a copy of the required documents to the Benefits Office within 31 days of the special enrollment event.

Your new coverage starts on the first of the month following the receipt of the change form and Dependent Documentation based on the special enrollment event. In case of birth or adoption of a child, the new coverage starts on the date of the event if the change form and Dependent Documentation were received within 31 days of such event.

When Coverage Ends

Your coverage ends on the last day of the month in which:

- You are no longer a Benefits-Eligible Employee.

- You stop working for the University.
- You die.
- You stop paying direct-billed premiums.
- The plan ends.

Coverage for your Dependents ends on the last day of the month in which:

- Your coverage ends.
- Your covered child reaches age 26 or 30 for military veteran dependents.
- Your covered child marries.
- Your double or family coverage ends.
- You and your spouse are divorced or legally separated, or your domestic partnership ends.
- In the case of your death, your Dependent's coverage would otherwise end (e.g., child reaches age 26 or 30, child marries).

In addition, coverage for your Dependents also ends on the:

- Last day for which required contributions were paid.
- Day of your Dependent's death.

When your coverage ends, you and/or your covered Dependents may be eligible to continue coverage for a limited time under COBRA.

Certificate of Coverage

When coverage under the medical plan ends for you and your eligible Dependents, you automatically will receive a certificate of coverage. This certificate will provide you with evidence of the insurance coverage (periods and types of coverage) you or your Dependents had under the plans.

You may present this certificate to a new health care plan to reduce or eliminate any pre-existing condition waiting period the new plan may have.

Coverage During a Leave

Short-Term Disability
If you are a staff employee and are not Actively at Work due to an approved short-term disability leave, your medical coverage will remain in place at the same level as before your leave. The costs for the coverage will be deducted from your short-term disability paycheck. Upon return to work from this leave, your cost for medical coverage will be deducted again from your regular paycheck.

Family Medical Leave
If you are not Actively at Work due to an approved leave of absence under the Family and Medical Leave Act (FMLA), you may continue your coverage at the same level as before your leave. You will be billed on a monthly basis for this coverage. Upon return to work from this leave, your cost for medical coverage will automatically be deducted again from your paycheck.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your leave, your medical coverage will end. The University reserves the right to recover from you the

premiums it paid for your and your Dependents' coverage if you fail to return to work unless the failure is due to your serious health condition or circumstances beyond your control.

If you are on unpaid FMLA leave, you may also cancel your coverage when your leave starts and reinstate your coverage (at the same coverage level) when your leave ends.

Leave of Absence
If you are not Actively at Work due to an approved, unpaid leave of absence, you may continue your medical coverage at the same level as before your leave.

If you decide to continue your medical coverage while on an unpaid leave of absence, you will be billed for your cost of coverage on a monthly basis. For the first three months, you will be billed for the coverage at the rate for employee's Actively at Work. After the first three months, you will be billed for the coverage at the full cost.

If you continue your medical coverage for at least the first three months of a Leave of Absence you may re-enroll in your medical coverage upon your return by contacting the Benefits Office. When you return to work in the same or another benefits-eligible position, your medical coverage will resume at the same level as before your leave. The cost for the medical coverage will automatically be deducted again from your paycheck.

If you decide not to continue your medical coverage while on leave, your medical coverage will end. You will not be eligible to enroll in a medical plan until the next Open Enrollment after your return from your leave of absence.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your leave, your medical coverage will end.

Long-Term Disability
For the duration of the long-term disability leave, you may continue your medical coverage at the same level as before your leave. You will be billed for the cost of coverage on a monthly basis. If you fail to pay, you may jeopardize your coverage.

If you return to work as a Benefits-Eligible Employee, your coverage will automatically continue and the cost for the medical coverage will be deducted again from your paycheck.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your long-term disability leave, your medical coverage will end.

Military Leave of Absence
If you are in the Reserves and are called up for active military duty, you may continue your medical coverage at the same level as before your leave, for up to 24 months. You will be billed for the cost of the coverage on a monthly basis. During the first three months of your leave, you will be billed at the active employee rate; thereafter you will be billed for the full monthly cost of coverage. If you fail to pay, you may jeopardize your coverage. The time period that you are eligible for continuation of coverage under COBRA runs concurrently with this Military leave continued coverage.

If you return to work in the same or another benefits-eligible position, your coverage will automatically continue and the cost for the medical coverage will be deducted again from your paycheck.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your leave, your medical coverage will end.

If you are on unpaid Military leave, you may also cancel your coverage when your leave starts and reinstate your coverage (at the same coverage level) when your leave ends.

How the Maroon Plan Works

Your Options

You can choose from three coverage levels:

- **Employee** covers you only.
- **Double** covers you plus one Dependent. For example, you could cover yourself and one child or yourself and your spouse (or Domestic Partner).
- **Family** covers yourself and two or more Dependents.

How It Works

The Maroon Plan is a Preferred Provider Option (PPO). Each time you need care; you can visit any eligible licensed provider you choose. Generally, you pay the Deductible then the plan covers a percentage of the cost of your Medically Necessary Care. Once you reach your out-of-pocket maximum, the plan pays 100% of covered benefits for the rest of the year.

If you visit a network provider, your care is considered "in-network," and the plan covers a higher percentage of your costs. Your doctor submits your claims directly to the Maroon Plan claims administrator.

If you do not visit a network provider, your care is considered "out-of-network," and the plan pays less. You file your own claims. Plus, if you are admitted to an out-of-network Hospital, you must meet an additional $200 Deductible before the plan pays benefits. Amounts above the eligible or allowable charges are not covered and do not apply toward your Deductible or your out-of-pocket maximum.

Claims must be filed within 24 months of the date of service. Any claims received after 24 months will not be considered under the plan.

The table shows the Deductibles, Coinsurance amounts, out-of-pocket maximums and Lifetime Maximum benefits.

For a current list, visit our web site at http://hr.uchicago.edu or contact the Benefits Office.

	In-Network	Out-of-Network
Choice of Providers	Network	Any provider
Deductibles	Individual: $250 Individual plus one: up to $500 Family: up to $600	Individual: $250 Individual plus one: up to $500 Family: up to $600 Each Hospital admission: $200
Coinsurance		
Most Services	Plan pays 80%, you pay 20%	Plan pays 65% of eligible or allowable charges, you pay the rest
Prescription Drugs	Retail: Copayment: $8 generic, $20 preferred brand-name, $35 non-preferred brand-name (30 day supply) Mail Service: $16 generic, $40 preferred brand-name, $70 non-preferred brand-name (90 day supply)	
Eligible or Allowable Charges	No fee schedule	Your provider may charge more than the eligible or allowable charges. You are responsible for these added charges. These charges do not count toward your Deductible or Out-of-Pocket Limit.
Lifetime Maximum	$2,000,000 per person; $50,000 for infertility treatment	
Claims	Provider files them for you.	You file your own claims.
Out-of-Pocket Limit	Out-of-pocket Maximum Is Based on Your Salary	

Your Salary	Individual	Family
Under $39,000	$1,000	$2,000
$39,000 - $65,999	$2,000	$4,000
$66,000 - $89,999	$3,000	$6,000
$90,000 or more	$4,000	$8,000

Medically Necessary Care

The plan pays a share of the covered expenses for Medically Necessary Care. **Medically Necessary Care** is a specific health care or Hospital service that is necessary for the treatment or management of a medical symptom or condition, and is the most efficient and economical care that can be safely provided. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary. The claims administrator determines whether a service is medically necessary.

Deductibles

A **Deductible** is the portion of your medical expenses you pay before the plan begins to pay benefits. There is an individual and family annual Deductible. In addition, if you or your covered Dependents are admitted to an out-of-network Hospital, you pay an additional $200 Deductible for each admission unless it qualifies as an emergency or you were out of the network area at the time services were rendered.

Coinsurance

Coinsurance is the portion of covered medical bills that you pay for Medically Necessary Care once your annual Deductible is satisfied. For example, if your Coinsurance is 20%, you pay 20% and the plan pays 80% for the covered service. Your Coinsurance amount is applied toward your Out-of-Pocket Limit.

Eligible or Allowable Charges
If you visit an out-of-network provider, your Coinsurance is subject to **the eligible or allowable charges**. That means you are responsible for any amount which the claims administrator determines is in excess of what in-network providers in your area generally charge for a specific service.

Out-of-Pocket Maximum
An **out-of-pocket maximum** is a cap on how much you have to pay for your family's covered medical expenses in a calendar year. After you reach the out-of-pocket maximum, the plan pays 100% of all remaining covered expenses for that year.

The individual and family Deductible is counted toward the out-of-pocket maximum.

For Example
Mark works at the University and enrolls himself and his wife in the Maroon Plan. He earns $31,000, so his Out-of-Pocket Limit is $2,000 a year. By October, Mark has paid $800 in the Deductible and Coinsurance, and his wife has paid $1,200. Because they have reached the Out-of-Pocket Limit of $2,000 for the year ($800 + $1,200 = $2,000), their covered expenses for the rest of the calendar year will be paid in full.

The out-of-pocket maximum does **not** include:

- The $200 Deductible for each admission to an out-of-network Hospital.
- Expenses that are not covered by the plan.
- Any extra costs incurred for not following procedures.
- Charges over the maximums allowed by the plan.
- Outpatient mental health services over the maximum amount allowed under the plan.
- Amounts above the eligible or allowable charges.
- Wellness services beyond the $300 payable under the plan.
- Prescription drug Copayments.

Lifetime Maximum
The **Lifetime Maximum** of $2 million is the most each covered person can receive from the Maroon Plan. If you or a covered Dependent reaches the $2 million limit, the plan will go back and restore up to $5,000 on January 1 of each year.

Advantages of Using In-Network Providers

Your health care costs are less by using an in-network provider. Visiting in-network providers offers several advantages, including:

- Health care providers who belong to the network must meet high standards.
- Network providers charge discounted rates for services and cannot charge more than the eligible or allowable charges.
- Your Coinsurance for most in-network services is less. If you do not use the network, you pay more in Coinsurance plus an added Deductible for each Hospital admission.

To find out if your doctor or Hospital is in this network, visit Blue Cross Blue Shield of Illinois' website at www.bcbsil.com. To find out if your pharmacy is in the network, visit Caremark at www.caremark.com. Participating provider directories are also furnished directly by Blue Cross Blue Shield or Caremark without charge as a separate document.

When You Must Pre-certify Care

To get the maximum benefit from the plan, you, a family member or your doctor must call the claims administrator:

- One business day before a scheduled Hospital admission.
- One business day before you are admitted to a Hospital for mental health or substance abuse therapy, Skilled Nursing Facility, coordinated home health care program or partial hospitalization psychiatric treatment program, except in an emergency.
- Within two business days after an emergency admission.

If you receive care outside the United States, you are not required to call.

If You Don't Pre-certify

If you do not call to pre-certify a scheduled Hospital admission or emergency admission, the first $250 of your expenses will not be covered.

Care that is not determined as medically necessary by the claims administrator will not be covered.

Information You Will Need When You Call

You will be asked to provide the following information:

- The covered employee's name and Social Security number.
- Employer name (University of Chicago).
- Group medical plan number (refer to your I.D. card).
- The patient's name, address, date of birth and Social Security number.
- If surgery is recommended, the type of surgery and length of stay.
- Hospital name, address and telephone number.
- Date of planned admission or date you were admitted for an emergency.
- Doctor's name, address and phone number.

What Happens After You Call

Once you call, your information will be reviewed. If necessary, a physician will talk with your doctor to discuss the proposed treatment plan and length of your Hospital stay to determine whether it is medically necessary. You, your doctor, the Hospital and the claims administrator will be notified of whether they will approve the treatment plan and Hospital stay. If your Hospital stay is extended beyond the approved stay, you or your physician should call (by your last day of the approved stay) to pre-certify any additional days.

Alternative medical care may be recommended, which may not be otherwise covered under the plan. Upon recommendation and the consent of the attending physician, the University and you, you may be reimbursed for services that are not otherwise covered (for example, home health care expenses instead of continued hospitalization).

To get maximum coverage under the plan, you must call before any admission to the Hospital. The toll-free number is on your medical ID card. If you do not call and receive approval, the first $250 of your expenses will not be covered. This amount does not count toward your Out-of-Pocket Limit.

What Is Covered

The table below describes what the Maroon Plan covers. Unless otherwise noted, the Deductible must be met before the plan pays benefits. Once you reach the Out-of-Pocket Limit, the plan pays 100%. See How it Works.

Covered Service	Maroon Plan Pays
Ambulance Transportation Benefits cover ambulance transportation when it is necessary due to the patient's condition to the nearest Hospital, Skilled Nursing Facility or from a non-network Hospital to the nearest network Hospital. Coverage is limited to the first trip to and from the Hospital for any one injury, illness or pregnancy. Benefits will not be paid for long distance trips or for the use of an ambulance for the patient's or family's convenience.	80%
Chiropractic/Muscle Manipulations and Naprapathy Therapy/Services Must be referred by a physician and provided by a state-licensed chiropractor. Maintenance therapy is not covered. For each condition, the utilization review organization will review treatment to determine medical necessity after 20 therapy sessions.	Naprapathy: 80% Chiropractic/Muscle Manipulations: In-network: 80% Out-of-network: 65%
Consultations Covers consultations requested by your attending physician. The consulting physician must have a special skill or knowledge that applies to the diagnosis or treatment for the condition.	In-network: 80% Out-of-network: 65%
Coordinated Home Care Services must be provided by a Home Health Care Agency and begin within 14 days of discharge from a Hospital or Skilled Nursing Facility. The home health care may include skilled nursing services and services of physical therapists, Hospital labs and medical supplies but does not include private duty nursing. Call the claims administrator for approval or the expenses will not be covered by the plan.	100% up to 120 visits a year.
Diagnostic Services Covers inpatient and outpatient diagnostic services ordered by a physician, dentist or podiatrist including x-rays related to covered inpatient surgery, x-rays related to the correction of fractures or complete dislocations, and surgical pathology related to covered surgery.	In-network: 80% Out-of-network: 65%
Durable Medical Equipment Covers rental (not to exceed the purchase price) or, at the option of the claims administrator, purchase of medical equipment required for temporary therapeutic treatment of an illness or injury, or to replace a bodily function lost or impaired due to illness, injury or congenital defect. The equipment must be used to serve a medical purpose.	80%
Elective Abortions Covered if legal where performed.	In-network: 80% Out-of-network: 65%
Emergency Accident Care Benefits cover initial outpatient treatment and related diagnostic services for accidental injuries when treatment occurs within 72 hours of the accident.	80%
Emergency Medical Care Benefits cover sudden and unexpected onsets of severe medical conditions (such as chest pains, convulsions and persistent abdominal pains) that would lead you to believe that in the absence of immediate medical care would likely result in serious and permanent medical consequences.	80%

Covered Service	Maroon Plan Pays
Medical Care Outside the United States Medical care services are covered the same as in the United States. The original provider bill should be submitted with a claim form. Claims in a foreign language must be translated into English and will be paid in U.S. currency using the exchange rate on the date of the claim.	80%
Hospice Care Includes supportive services and providing physical, psychological, social, and spiritual care for dying persons and their families. Care can be received in your home, inpatient Hospital or Skilled Nursing Facility. See Hospice Care for details.	100%
Hospital Services – Inpatient Includes bed, board and routine nursing care up to the hospitals most common semi-private room rate or special charges for intensive care confinement, and ancillary services such as operating rooms and drugs, and surgical dressings and lab work.	In-network: 80% Out-of-network: 65%
Human Organ Transplants Contact the utilization review organization to find out whether your transplant is covered and where you can have the service performed. Provides benefits for a medically necessary human organ transplant. If both the donor and recipient have their own coverage, each will have his/her claims paid by his/her own plan. If you are the recipient and the donor has no health care coverage, benefits under this plan will be provided for both you and the donor with payments made to the donor charged against your Lifetime Maximum. If you are the donor and the recipient has no health care coverage, you will receive benefits from this plan but the recipient will not. Covered transplants performed at any facility include parathyroid, muscular skeletal, heart valve, cornea, kidney and bone marrow. In addition, for heart, lung, heart/lung, liver, pancreas or pancreas/kidney organ or tissue transplants, benefits begin no earlier than five days before and 365 days after the transplant surgery, and transportation expenses within the U.S. and Canada for the donor organ to the location of the transplant surgery is covered. **However, coverage is only provided if the transplant is performed at a Hospital with a Human Organ Transplant Program approved by the claims administrator.** The plan does not cover investigational drugs, travel time and related expenses required by a provider; transportation by air ambulance for the donor or recipient; and cardiac rehabilitation services not provided to the transplant recipient within three days after discharge from a Hospital for transplant surgery.	In-network: 80% Out-of-network: 65%
Infertility Treatment Covered expenses include uterine embryo lavage, embryo transfer, artificial insemination, in vitro fertilization, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and low tubal ovum transfer for covered individuals who can not conceive after one year of trying in the normal manner or who cannot sustain a successful pregnancy. For in vitro, GIFT and ZIFT, expenses are covered only if the patient was unable to attain or sustain a successful pregnancy through the other covered procedures, the patient hasn't completed four oocyte retrievals (except that if a live birth follows a complete oocyte retrieval, then two more complete oocyte retrievals are covered), and the procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines or the American Fertility Society minimal standards for in vitro fertilization. Expenses above the lifetime limit of $50,000 are not covered by the plan.	In-network: 80% Out-of-network: 65%

Covered Service	Maroon Plan Pays
Maternity Services Certain services for newborn infants are covered as part of the mother's delivery charges, including routine inpatient Hospital nursery charges incurred immediately after birth, and one routine inpatient examination by a physician, other than the physician who delivered the child or administered anesthesia. If treatment is needed for an ill or injured newborn child, benefits will be paid for that care if there is family coverage. Certified nurse-midwife care is covered.	In-network: 80% Out-of-network: 65%
Dental Accident Care Benefits will be paid for medical services that a dentist or physician provides after an accidental injury to the jaws, teeth, mouth or face. These services are covered only if the injury occurred on or after your coverage begins.	80%
Mental Health Services – Inpatient Covers partial psychiatric Hospital treatment if medically necessary and pre-certified. If you don't pre-certify, benefits may be reduced.	In-network: 80% Out-of-network: 65%
Mental Health Services – Outpatient Covers psychotherapy, group therapy, marriage and family therapy and psychological testing. Counseling for family members is covered when necessary to assist in treating the patient. Services must be provided by a physician, clinical psychologist, licensed clinical professional counselor, licensed marriage and family therapist or licensed social worker.	In-network: 80% Out-of-network: 65%
Oral Surgery Benefits for surgery performed by a dentist are limited to: • Excision of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth. • Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth if the injury occurred after your coverage began. • Excision of exostosis (bony outgrowth) of the jaws and hard palate, provided this procedure is not done in preparation for dentures or other prostheses. • Treatment of facial bone fractures. • External excision and drainage of cellulitis. • Incision of accessory sinuses, salivary glands or ducts. • Reduction of dislocation or excision of the temporomandibular joints. • Effective July 1, 2003 removal of bony impacted wisdom teeth.	In-network: 80% Out-of-network: 65%
Other Covered Services Services provided by a physician or Hospital including radiation therapy; chemotherapy; renal dialysis treatments in a Hospital, dialysis facility, or your home under the supervision of a dialysis facility; shock therapy; physical therapy provided by a registered physical therapist; occupational therapy provided by a registered occupational therapist; chiropractic therapy provided under a physician's referral to a state-licensed chiropractor; allergy shots and surveys; and mammograms.	In-network: 80% Out-of-network: 65%

Covered Service	Maroon Plan Pays
Other Equipment, Supplies and Appliances Benefits cover the following when ordered by a physician: • Oxygen and its administration. • Blood and blood components. • Leg, back, arm and neck braces when required because of an illness beginning or injury occurring on or after coverage date. • Medical and surgical dressings, supplies, casts and splints. • Durable medical equipment such as cardiac valves, internal pacemakers, bone screws, bolts, nails, plates, and other internal and permanent devices as reasonably approved by the claims administrator.	80%
Physical and Occupational Therapy Must be provided by a licensed professional therapist. Maintenance therapy and educational training designed to develop a physical function are not covered. For each condition, the utilization review organization will review treatment to determine medical necessity after 20 therapy sessions.	In-network: 80% Out-of-network: 65%
Physician's Services Covers services provided at your doctor's office or in your home; while you are an inpatient in a Hospital, Skilled Nursing Facility or substance abuse treatment facility; or are a patient in a partial hospitalization psychiatric treatment program or coordinated home care program.	In-network: 80% Out-of-network: 65%
Pre-admission Testing Covers outpatient tests given by a Hospital in preparation for scheduled inpatient surgery.	100%
Pre-existing Conditions	Covered at same level as any other medical condition.
Prescription Drugs Covers prescription drugs and medicines dispensed by a licensed pharmacist or physician with a written prescription at a participating pharmacy or through the mail order program. Drugs must be approved by the U.S. Food and Drug Administration for general use by humans, including oral contraceptives. Most contraceptives that you receive from your physician, such as intrauterine devices (IUD's), diaphragms, implants (e.g., Norplant) and non-self-administered injectables (e.g., Depo Provera), are covered by your medical plan. Contact your medical plan for more information.	**Participating Retail Pharmacy:** For 30-day supply – 100% after $8 Copayment for generic, $20 Copayment for preferred brand-name or $35 Copayment for non-preferred brand-name **Mail Order:** For 90-day supply – 100% after $16 Copayment for generic, $40 Copayment for preferred brand-name or $70 Copayment for non-preferred brand-name
Private Duty Nursing Services Benefits cover services for an inpatient when the claims administrator determines that the regular nursing staff would not provide necessary care, and home services could not be provided by non-professional personnel. Expenses for nursing services provided by immediate members of family are not covered by the plan.	80%
Prosthetic Appliances Covers prosthetic appliances, devices and surgical implants required to replace: • All or part of an organ or tissue of the human body, or • All or part of the function of an organ or tissue of the human body. Benefits also cover adjustments, repair and replacements of these	80%

Covered Service	Maroon Plan Pays
appliances when necessary because of wear or change in condition.	
Second or Third Opinions If your doctor recommends surgery, you can call the utilization review organization for the names of doctors who can provide you with a second opinion. If the second surgical opinion does not confirm the need for surgery, benefits will be provided for a third opinion. Your benefits for a second or third opinion are the same as for a first surgical opinion.	In-network: 80% Out-of-network: 65%
Skilled Nursing Facility Care Covers bed, board and routine nursing care at the most common semi-private room rate, as well as ancillary services such as drugs, surgical dressings or supplies at an approved Skilled Nursing Facility. You must be admitted within 14 days of discharge from a Hospital or coordinated home care program. Custodial care services are not covered. Call the claims administrator for approval or no expenses will be covered by the plan.	100% up to 120 days each year.
Speech Therapy Must be provided by a licensed or American Speech and Hearing Association-certified therapist. Covers services for an inpatient admitted to a Hospital for another reason. Maintenance therapy and educational training is not covered. Speech therapy is reviewed after 20 therapy sessions to determine medical necessity.	In-network: 80% Out-of-network: 65%
Substance Abuse Treatment Benefits cover all services already described in this section, if treatment for substance abuse takes place in a Hospital or substance abuse treatment facility.	In-network: 80% Out-of-network: 65%
Surgery and Related Services Includes inpatient and outpatient surgery performed by a physician, dentist or podiatrist; anesthesia; and assistant surgical services performed by a physician, dentist or podiatrist if a Hospital intern or resident is not available to provide such assistance.	In-network: 80% Out-of-network: 65%
Wellness Care Covers annual routine physical exams and related diagnostic tests (such as digital rectal exam, colorectal cancer screening and prostate test), immunizations, influenza vaccinations and routine gynecological exams (such as Pap tests but excluding mammograms) provided by a physician.	100% up to $300 per calendar year for each covered person. There is no additional coverage for wellness care once the $300 wellness benefit has been provided.

Hospice Care Benefits

The plan pays 100% of eligible and allowable hospice care charges. The care must be received from a licensed Hospice Care Program provider. The patient must have a life expectancy of six months or less. Covered hospice care benefits include:

- Physician visits.
- Nursing services.
- Medication.
- Physical therapy.
- Occupational therapy.
- Pain management services.
- Medical supplies and dressings.
- Social and spiritual services.
- Bereavement counseling. A covered provider must perform this service.

- Skilled Nursing Facility care: For purposes of the annual limit of 120 days in a Skilled Nursing Facility, two days in a Skilled Nursing Facility will be considered as one day when the Skilled Nursing Facility stay is part of hospice care. For this benefit, you do not have to be admitted within 14 days of discharge from a Hospital or coordinated home care program.
- Coordinated home care: For purposes of the limit of 120 coordinated home care visits a year, three coordinated home care visits will be considered one visit if the visits are part of hospice care. For this benefit, services do not have to begin within 14 days of discharge from a Hospital or Skilled Nursing Facility.

Hospice care does not include durable medical equipment; home delivered meals; homemaker services; respite care; traditional medical services provided for the direct care of the terminal illness, disease or condition; or transportation.

Health Protection for Newborns and Mothers
Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Coverage for Breast Cancer
As required by the Women's Health and Cancer Rights Act of 1998, this plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). Call the claims administrator for more information.

What Is Not Covered

The Maroon Plan does not cover:

- Services that exceed the eligible or allowable charges or the maximums allowed by the plan.
- Physician's fees for staff consultations required by Hospital rules and regulations.
- Claims filed after 24 months from the date of service.
- Services or supplies:
    - Received before the patient was covered by the plan.
    - That is not medically necessary, as determined by the claims administrator. In some cases, the utilization review organization will provide an opinion.
    - That you are entitled to under workers' compensation or other laws.
    - Furnished by the local, state or federal government.
    - For which payment or benefits are available from the local, state or federal government (for example, Medicare), whether or not you receive that payment or benefit (except as otherwise provided by law).
    - For any illness or injury occurring on or after your coverage date as a result of war or an act of war.
    - That does not meet accepted standards of medical or dental practice, including, but not limited to, experimental services and supplies, and services primarily for research.

    - Received during an inpatient stay when the stay is related to behavior, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of mental illness.
    - You are not required to pay for or would have no legal obligation to pay for if you did not have this or similar coverage.
    - For human organ or tissue transplants other than those specified in the plan document.
    - For which benefits are duplicated because the spouse, parent and/or child are employees of the University and each is covered separately by the plan.
- Custodial care services or education or training, or educational therapy, including treatment of learning disorders.
- Home delivery of meals or homemaker services.
- Routine physical examinations and immunizations, after the $300 wellness benefit has been provided.
- Cosmetic surgery and related services and supplies, except correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases.
- Charges for failure to keep a scheduled visit, completion of a claim form, telephone advice or physicians travel time.
- Personal hygiene, comfort or convenience items such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones, commonly used for purposes other than medical reasons.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus and battery or atomically controlled implants, unless specifically stated in the plan document.
- Procurement or use of prosthetic devices, special appliances and surgical implants that are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Blood derivatives not classified as drugs in the official formularies.
- Blood or blood plasma for which the patient receives a refund or allowance, but only to the extent of the refund or allowance.
- Charges after the first pair of eyeglasses, contact lenses or lenses used to treat cataracts.
- Artificial eyes, and replacement of cataract lenses unless the prescription has changed.
- Examinations for prescribing or fitting glasses or contact lenses or for determining the refractive state of the eye and any surgical treatment to correct refractive error except due to an accidental injury while covered by the plan.
- Routine dental care.
- Care and treatment of the teeth and gums unless required by an injury to natural teeth and for certain cutting procedures to the oral cavity.
- Treatment provided to alter vertical dimension or treatment of temporomandibular joint dysfunction not caused by joint disease or physical trauma.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions, and the treatment of subluxations of the foot.
- Treatment of routine foot care except for diabetics.
- Orthopedic shoes, except for diabetics, unless they are part of a leg brace and included in the orthopedist's charges.
- Maintenance care or maintenance occupational or physical therapy.
- Maintenance speech therapy and speech therapy for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability or mental retardation.
- Occupational, speech, physical, chiropractic and naprapathy therapy/services in excess of 20 visits for the same diagnosis, unless approved in advance.

- Hearing aids or examinations for the prescription or fitting of hearing aids.
- Diagnostic services:
    - As part of premarital examination.
    - For auditory problems.
    - For the determination of refractive errors of the eyes.
    - For surveys, case findings, research studies, screenings or similar procedures and studies, or tests which are investigational.
- Hospital confinements primarily for observation or diagnostic studies which could have been performed on an outpatient basis.
- Substance abuse treatment that is:
    - Court-ordered diagnostic evaluation,
    - Care in lieu of detention or correctional placement, or
    - Performed by other than a physician, registered clinical psychologist or licensed clinical professional counselor.
- Services performed by a close relative or someone who has the same legal address as the patient.
- Any service, treatment, drug or device that is considered experimental, educational or investigational; or is not recognized as generally accepted medical practice by the medical profession in the U.S. on the date the service or supply is rendered or received, as determined by the claims administrator.
- Intentionally self-inflicted injury (unless due to mental illness), or an injury or illness resulting from participation in an assault or felony.
- Charges for self-administered injectable medications, except insulin for diabetics and allergy injections.
- Acupuncture.
- Partial psychiatric hospitalization treatment unless approved in advance.
- Expenses for infertility treatment other than those listed under What Is Covered or for covered treatments in excess of $50,000 per person in a lifetime.
- Sterilization reversal.
- Treatment or surgery to change gender or improve or restore sexual function.

How HMOs Work

Your Options

Choosing an HMO
The University offers three HMO options:

- **University of Chicago Health Plan (UCHP)** is not formally organized as an HMO, but it works like one. UCHP doctors and facilities are affiliated with the University of Chicago Hospitals. UCHP facilities are located in Hyde Park and in several other locations. Contact UCHP for current information.
- Humana Premier HMO Plan is an HMO. As an Independent Practice Association (IPA), Humana contracts with doctors, clinics and hospitals throughout the Chicago area.
- HMO Illinois is an HMO operated by Blue Cross/Blue Shield of Illinois. As an Independent Practice Association (IPA), HMO Illinois contracts with doctors, clinics and hospitals throughout the Chicago area.

Each HMO offers slightly different benefits and covers different geographic areas. Before you choose an HMO, review the HMO's materials and visit the University's web site at

http://hr.uchicago.edu for additional details. The HMO's certificate of coverage (or terms of coverage) along with this document constitutes your summary plan description for the HMO.

Choosing a Coverage Level
Once you choose your HMO, you choose whom you will cover. You can choose from three coverage levels:

- **Employee** covers you only.
- **Double** covers you plus one Dependent. For example, you could cover yourself and one child or yourself and your spouse (or Domestic Partner).
- **Family** covers you, your children, and your spouse or Domestic Partner.

How It Works

An **HMO** is a structured group of local doctors, hospitals, health care providers and administrators organized to deliver comprehensive medical care to its members at pre-negotiated fees.

As long as your care is coordinated by your Primary Care Physician, an HMO generally covers 100% of the cost for approved care – some plans may require Copayments. Coverage includes preventive care such as physicals, mammograms, gynecological exams, well-child care and immunizations, and prescription drugs. Some HMOs offer limited vision care benefits. There are no claim forms to file and no Deductibles, reasonable and customary limits or Out-of-Pocket Limits.

In most cases, you must use your HMO's doctors and hospitals to receive benefits. If you go to a doctor or Hospital outside your HMO for care without prior approval, you will not receive any benefits from the plan, except for emergencies (see In an Emergency). Contact your HMO for the locations of your HMO's medical facilities. The HMO furnishes HMO provider directories without charge as a separate document. HMO provider directories are also available at the following websites: www.bcbsil.com and www.humana.com.

Your Primary Care Physician (PCP)
When you enroll in an HMO, you must choose a Primary Care Physician (PCP). Your PCP coordinates all of your medical care. When you need care, you must call or visit your PCP first. If it is medically necessary, he or she will refer you to a specialist. Your PCP's responsibilities include:

- Giving you regular checkups.
- Providing treatment when you are ill.
- Ordering necessary X-rays, lab work and other tests.
- Referring you to a specialist.
- Arranging for outpatient treatment or hospitalization.
- Filing your claims.

Each member of your family may have his or her own PCP.

You can change your PCP as often as you want (monthly for UCHP). To change your PCP, call your HMO. Generally, if you call your HMO before the middle of the month, the change will take effect on the first day of the following month.

Referrals
When your PCP determines that you need to see a specialist, he or she will give you a referral form. **You must get a referral form before you see a specialist.** For UCHP, you will also need Health Plan approval if the specialist is not a UCPG specialist. If you schedule an appointment or get care without a referral from your PCP, you must pay for the services you received.

If your PCP refers you to a specialist:

- Make a copy of the referral for your records. You may need one later to prove you should not be billed for the specialist's services.
- Go to the specialist within the designated time period. If you go later, you have to pay the cost of the visit yourself.
- Go to the specialist only for the designated number of visits. If you go more often than that, you have to pay the cost of the additional visits.
- Contact your PCP if you need to have the designated time period changed or the designated number of visits extended.

In an Emergency
Emergencies are conditions that require immediate care. Typically, an emergency is considered to be an accidental injury or the sudden or unexpected onset of a severe medical condition such as chest pains, convulsions, loss of consciousness, head injuries, lacerations, or vomiting blood.

You may be liable for the cost of your emergency room visit if you do not receive approval for that visit from your HMO either before you go to the emergency room or within 24 or 48 hours after your visit.

When you follow the proper procedures, emergency care is covered by the HMOs 24 hours a day, 7 days a week, no matter where you are or what is needed.

Review your HMO materials for specific instructions and details about what to do in an emergency before you experience a life-threatening situation. Each HMO requires that you contact them within a specific time period following the emergency. Also, the definition of an emergency may vary, depending on the specific HMO.

What Is Covered

The table below briefly describes what is covered by each HMO. For specific covered services, see your HMO's materials.

Covered Service	UCHP	Humana Premier HMO	HMO Illinois
Ambulance Transportation	Provided in full for an emergency	Provided in full	Provided in full
Chiropractic and Naprapathy Services	Not covered.	Short-term therapy and rehabilitation is provided in full, if prescribed by Humana Premier HMO Plan physician.	Provided in full if referred by PCP.
Physical, Occupational and Speech Therapy	Provided in full up to 60 treatments combined per calendar year	Short-term therapy and rehabilitation is provided in full, if prescribed by	Provided in full if referred by PCP up to 60 treatments combined per

Covered Service	UCHP	Humana Premier HMO	HMO Illinois
		Humana Premier HMO Plan physician.	calendar year.
Drug and Alcoholism Services	Contact UCHP for available benefit information.	Contact Humana Premier HMO Plan for available benefit information at 1-800-448-6262.	Contact HMO Illinois at 1-800-346-3986 for available benefit information.
Hearing Services	Exam provided in full. No coverage for hearing aids.	Exam provided in full. No coverage for hearing aids.	Exam provided in full. No coverage for hearing aids.
Hospitalization - Inpatient Includes room and board, X-rays, lab tests, medications, physician and surgical care, and private-duty nursing.	Provided in full	You pay $100 copayment per day for the first three days of the hospital stay; after reaching $300, Plan covers the remainder.	Provided in full
Infertility Services	Services and procedures necessary to diagnose and treat infertility are provided in full (generally up to four oocyte per person per lifetime). Prescription drugs used to treat infertility are covered at 75% up to a Lifetime Maximum of $6,750.	Services and procedures for the diagnosis and treatment of infertility are provided in full (generally up to four oocyte per person per lifetime). Coverage is provided only under certain conditions for in-vitro fertilization and gamete or zygote intrafallopian tube transfer.	Artificial insemination, sperm washings and in-vitro fertilization (generally up to four oocyte per person per lifetime) are provided in full after $10 Copayment. All laboratory blood work, ultrasound testing and prescription drugs approved and referred by the PCP as they relate to infertility services are covered at 100%.
Maternity Care	Provided in full	Provided in full	Provided in full
Mental Health Care			
Inpatient	Limited to 30 days per person per calendar year.	Limited to 30 days per person per calendar year.	Limited to 20 days per person per calendar year.
Outpatient	Limited to 20 visits per person per calendar year. $20 Copayment each visit (waived for first visit each calendar year).	Limited to 20 visits per person per calendar year. $20 Copayment each visit.	Limited to 20 visits per calendar year. $20 Copayment each visit.
Outpatient Diagnostic Services Covers x-rays and lab tests.	Provided in full	Provided in full	Provided in full
Physical Exams	Provided in full	Provided in full once each calendar year	Provided in full

Covered Service	UCHP	Humana Premier HMO	HMO Illinois
Physician Office Visits Includes specialists.	Provided in full after $10 Copayment	You pay $10 copayment for a Primary Care Physician visit and $20 for a specialist visit; Plan covers the remainder	Provided in full after $10 Copayment
Pre-existing Conditions	Covered as long as treatment is a covered service under the plan.	Covered as long as treatment is a covered service under the plan.	Covered as long as treatment is a covered service under the plan.
Prescription Drugs			
Retail	Per prescription for up to 30-day supply: generic $5, preferred brand-name $15 and non-preferred brand-name $30 Copayment	Per prescription for up to 30-day supply: formulary generic $5, formulary brand name $15 and not on formulary $30 Copayment	Per prescription for up to 30-day supply: generic $5, preferred brand-name $15 and non-preferred brand-name $30 Copayment
Mail Order	Per prescription for up to a 90-day supply: generic $10, preferred brand-name $30 and non-preferred brand-name $60 Copayment	Per prescription for up to 90-day supply: formulary generic $10, formulary brand name $30 and not on formulary $60 Copayment	Per prescription for up to 90-day supply: generic $10, preferred brand-name $30 and non-preferred brand-name $60 Copayment
Skilled Nursing Facility	Provided in full	Provided in full for 120 days per calendar year if prescribed by a Humana Premier HMO Plan physician.	Provided in full
Vision Care	Routine eye exam provided for children under age 18; one visit to pediatric ophthalmologist to determine initial; unlimited visits at Children's group	Eye exam provided every 12 months at participating provider. One pair of eyeglasses or contacts covered up to $75 ($85 for trifocal and Lenticular lenses and frames) every 24 months.	$75 for eyewear purchase every 24 months. Routine vision exam provided by a participating provider covered in full after office Copayment. Additional discounts are available at Eye Med providers.
Coordinated Home Care	Provided in full	Provided in full when care is received by visiting nurses. House calls provided in full for emergency care as prescribed by a Humana Premier HMO Plan physician.	Provided in full when care is received by visiting nurses.

Health Protection for Newborns and Mothers

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and

issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Coverage for Breast Cancer
As required by the Women's Health and Cancer Rights Act of 1998, these plans provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema). Call your HMO for more information.

What Is Not Covered

For a detailed description of non-covered procedures and services, please refer to the HMO certificate of coverage (or terms of coverage). The HMO furnishes HMO certificates of coverage without charge as a separate document. HMO certificates may also be available at the following websites: www.bcbsil.com and www.humana.com. A brief set of examples of what is not covered include:

- Services or supplies that are not listed in the coverage certificate, that are not ordered by your Primary Care Physician, Woman's Principal Health Care Provider, or that you are entitled to under workers' compensation or other laws.
- Treatment that is not pre-certified, when required, as explained in your certificate of coverage (terms of coverage).
- Services or supplies that were received before the date your coverage began or after the date your coverage ended.
- Services or supplies furnished by or available from the local, state or federal government.
- Services for which benefits are duplicated because the spouse, parent and/or child are employees of the University and each is covered separately by the plan.
- Services or supplies provided as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the plan has provided benefits for the services or supplies in connection with such injury.
- Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are investigational or experimental in nature.
- Custodial care services.
- Services or supplies to treat behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of a mental illness.
- Special educational therapy such as music or recreational therapy.
- Cosmetic surgery and related services and supplies, except correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases.
- Charges for failure to keep a scheduled visit or for completion of a claim form.
- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Personal hygiene, comfort or convenience items such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones, commonly used for purposes other than medical reasons.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus or battery or atomically controlled implants, except as specifically stated in the HMO's certificate.

- Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.
- Nutritional items such as infant formula, weight-loss supplements and over-the-counter food substitutes.
- Blood derivatives that are not classified as drugs in the official formularies.
- Marriage counseling.
- Hypnotism.
- Outpatient private duty nursing.
- Routine podiatric care such as corn callus removal.
- Services or supplies that are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this Certificate.
- Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
- Services or supplies rendered for human organ tissue transplants except as specifically provided for in this Certificate.
- For any illness or injury occurring on or after your coverage date as a result of war or an act of war.

Receiving Your Benefits

Filing a Claim

Maroon Plan
You do not have to file a claim if you seek medical care from a network provider. If you use an out-of-network provider, file your claims within 24 months after the date you receive a covered service or supply. Otherwise your claim will not be paid as it will have exceeded the filing limit. To file a claim:

1. Ask the Benefits Office for a Maroon Plan claim form.
2. Complete the form.
3. Attach copies of the bills for the services and supplies, including:
   - The provider's name and address.
   - The patient's name.
   - Diagnosis.
   - Date of service.
   - Description of service.
   - Charge for service.
4. Mail the completed form and attachments to the claims administrator.

Be sure to keep copies of your claim forms and all supporting documentation. After your claim submission is processed, payment will be sent to you. You will receive a statement, called an Explanation of Benefits, telling you what was paid and the amount, if anything, you still owe to the provider. File separate claims for each covered individual.

HMOs
HMOs do not require you to file claim forms since most services are covered in full or for a small Copayment. However, you may need to file a claim to get reimbursed for emergency care that you receive at a non-HMO facility. Claims for emergency care received at a non-HMO facility should be sent to:

UCHP	Humana Premier HMO	HMO Illinois
180 North Harvester Drive Suite 110 Burr Ridge, IL 60527	Humana Claims Office P.O. Box 14601 Lexington, KY 40512-4601	300 East Randolph Chicago, IL 60601-5099

Timeframe for Claim Review
Benefits under the medical plan will be paid only if the Plan Administrator or its delegate decides, in its discretion, that you or your covered Dependents are entitled to them. The Plan Administrator will make a decision about your claim in the time frames outlined below and will notify you of its decision in writing.

Claims for benefits under a group health plan fall into four categories: urgent care, a claim requiring advance approval, approval of an ongoing course of treatment, and a claim for the payment of medical or dental services after they have been received ("Post-Service Claim"). The time frame within which you receive notification will depend on what kind of a claim has been made. Please pay attention to the following:

Urgent Care Claims
If a claim is urgent, you will be notified of the Plan Administrator's decision, adverse or not, as soon as possible taking into account the medical or dental circumstances, but not later than 72 hours after the plan received the claim, unless the claim does not contain sufficient information on which to base a decision.

If the claim is incomplete and additional information is required, you will be notified as soon as possible, but not later than 24 hours after the plan received the claim, of the information required and give you at least 48 hours to provide it.

You will then be notified of the Plan Administrator's decision as soon as possible, but not later than 48 hours after the earlier of:

- The receipt of any additional information by the plan; or
- The end of the 48 hours given to you to provide additional information.

A claim is "urgent" in the following cases:

- Where application of the 30-day time period for non-urgent care claims could reasonably be expected to seriously jeopardize your life or health or ability to regain maximum function;
- In the opinion of a physician with knowledge of your medical or dental condition, the application of the 30-day time period for non-urgent care claims would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim; or
- If a physician with knowledge of your medical or dental condition determines that a claim is urgent, such determination will be dispositive.

Claim Requiring Advance Approval or Pre-Authorization
If a claim is for a benefit requiring advance approval by the Plan Administrator (for example, a scheduled Hospital admission), you will be notified of the Plan Administrator's decision, adverse or not, within a reasonable period of time appropriate to the medical or dental circumstances, but not later than 15 days after the plan received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the plan's control.

If an extension is required, you will be notified before the end of the original 15-day period of the circumstances requiring the extension and the date by which a decision is expected.
If additional information is required, within five days of receiving the claim, the Plan Administrator will specifically describe it in the notice and give you a period of at least 45 days to provide it.

Approval of an Ongoing Course of Treatment
If the plan has approved an ongoing course of treatment to be provided over a period of time or approved a number of treatments, the following will apply:

- Unless the plan is amended or terminated, any reduction or termination in the course of treatment will be treated as an adverse determination on a claim (or a claim denial).
- The Plan Administrator will notify you sufficiently in advance to allow you to appeal and obtain a decision on appeal before the reduction or termination.

Post-Service Claim
If your claim is for the payment of services after they have been received, the Plan Administrator will decide within a reasonable time, but not longer than 30 days after the plan received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the plan's control.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances requiring the extension and the date by which a decision is expected. If additional information is required, the Plan Administrator will specifically describe it in the notice and give you a period of at least 45 days to provide it.

The Plan Administrator may secure independent medical, dental or other advice and require such other evidence as it deems necessary to decide your claim.

If Your Claim Is Denied

Notification of Denial
If the Plan Administrator issues an Adverse Benefit Determination, you can request to have your claim reviewed and reconsidered. An "Adverse Benefit Determination" includes:

- Coverage denial,
- Denial because the service is experimental, investigational or not medically necessary, or
- Reduction or termination in an ongoing course of treatment (except due to plan amendment or termination).

The written explanation of the denial will be provided by the Plan Administrator and it will state:

- The specific reasons for the denial,
- A reference to the specific plan provision on which the denial is based,
- If the Plan Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

Appealing Denied Claims

You may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of the Plan Administrator's initial notice of an Adverse Benefit Determination (or claim denial), or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You can also ask additional questions and make written comments, and you may review (at no charge) documents or other information relevant to your appeal.

All written comments and documents you submit with your appeal, whether or not considered in the initial claim determination, will be reviewed and considered on appeal.

Review of Appeal

An independent fiduciary (or in the case of UCHP, a committee of UCPG physicians) will review and give a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The independent fiduciary will not be an individual who participated in or decided your original claim nor be a subordinate to the original decision maker. No deference will be given to the initial decision. The independent fiduciary may consult with a physician or other licensed health care professional to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical or dental expert consulted in connection with your appeal will be different from any expert consulted in your initial claim. (The identity of a medical or dental expert consulted in connection with your appeal will be provided.)

The time frame review of your appeal, like your initial claim for benefits, depends on whether it is an urgent care claim, a claim requiring advance approval or pre-authorization, approval of an ongoing course of treatment or post-service claim. Please pay attention to the following time frames:

Urgent Care Claims
If your appeal is in connection with an urgent care claim, the Plan Administrator will notify you of its decision on appeal as soon as possible taking into account medical or dental circumstances, but not later than 72 hours after the plan received the appeal.

Claim Requiring Advance Approval or Pre-Authorization
If your appeal is in connection with a claim for benefits requiring advance approval by the Plan Administrator, you will be notified of its decision on appeal, adverse or not, within a reasonable period of time appropriate to the medical or dental circumstances, but not later than 30 days after the plan received your appeal.

Approval of an Ongoing Course of Treatment
If your appeal is in connection with a claim for an ongoing course of treatment, the Plan Administrator will notify you of its decision on appeal as soon as possible, but not later than the date your treatment ends or is reduced.

Post-Service Claim
If your appeal is in connection with a claim for payment of services after they have been received, the Plan Administrator will notify you of its decision on appeal, adverse or not, but not later than 60 days after the plan received appeal.

Notification of Appeal Denial
If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of Adverse Benefit Determination on review setting forth:

- The specific reason(s) for the denial,
- The specific plan provisions on which the decision is based,
- A statement of your right to review (on request and at no charge) relevant documents and other information, and
- If the Plan Administrator relied on an internal rule, guideline, protocol or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you on request.

The decision of the Plan Administrator is final and binding.

The insurance company will comply with shorter time limits if required by the state in which the policy was issued.

Coordination of Benefits

Many individuals have medical coverage in addition to their coverage under the University's plans. For example, you may be covered as a dependent under your spouse's medical plan. This "Coordination of Benefits" provision prevents duplication of benefit payments when you or your Dependent(s) also have coverage through another group plan. Coordination of Benefits procedures also determines which plan pays first.

How Coordination of Benefits Works
The first step in coordinating benefits between two or more group plans is to determine which plan is primary and which plan is secondary. The primary plan pays benefits first. The secondary plan then pays its benefits so that the total benefit paid from both plans is not more than 100% of the

allowable expense. No plan pays more than it would pay without Coordination of Benefits. If none of the following apply the plan that covers the patient the longest is primary.

Order of Coverage for You
If you are covered as an employee by one plan and as a dependent by another, the plan that covers you as an employee pays benefits first. If you are covered by both an active medical plan and a retiree medical plan (one of them through another employer), the active plan is primary.

Order of Coverage for Dependent Children
If your child is covered under both your and your spouse's medical plan, the plan of the parent whose birthday comes first during the calendar year is the child's primary medical plan. If two or more medical plans cover a Dependent child of divorced or separated parents, benefits for the child are determined as follows:

- First, the medical plan of the parent who has a court decree of financial responsibility will be primary.
- If no such court decree exists, then the medical plan of the parent who has custody of the child will be primary.
- Then, the medical plan of the spouse of the parent who has custody of the child will be primary.
- Finally, the medical plan of the parent who does not have custody of the child will be primary.

Payments
A payment made by another group program may include an amount that should have been paid by the University plan. If so, the claims administrator may repay that amount to the organization that made the payment.

Coordination with Medicare
Medicare is available to individuals at age 65 or after two years of receiving Social Security disability benefits. The University remains the primary plan for active employees age 65 and over and their Dependents, regardless of age. Medicare is the primary plan for former employees age 65 and over and their Dependents age 65 and over who are covered as retirees under the University plan.

In situations involving end-stage renal disease (ESRD), regardless of age or Medicare status, the University plan is primary for the first 30 months of ESRD. After 30 months of ESRD entitlement, Medicare becomes primary.

Benefit Overpayments
If an overpayment is made by the medical plan, the person or organization that received the benefit must repay the excess amount to the claims administrator.

Right of Recovery
When you are injured or ill because of the actions of a third party, the plan may cover your eligible expenses. However, to receive coverage, you must notify the plan that your illness or injury was caused by a third party, and you must follow special plan rules. The plan has the right (called subrogation) to recover expenses it pays for that illness or injury.

To exercise its right of subrogation, the plan may:

- Place a lien against any responsible party or other third party recovery to the extent the plan paid benefits,
- Bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved, and
- Suspend the payment of any plan benefits pending receipt from the covered person of any acknowledgement, agreement, authorization, waiver or release it considers necessary to exercise its rights or privileges under the plan.

If you receive a payment (through a judgment, settlement or otherwise) when an injury is someone else's fault, you must pay the plan back first, in full, for any expenses the plan has paid. You must pay the plan back in full regardless of whether your settlement or judgment says that the money you received is for expenses covered by the plan and regardless of whether you have been made whole. If any money is left over, you may keep it.

The plan will not pay any attorney fees or costs associated with a lawsuit.

You are responsible for furnishing the information, assistance and/or documents to help the claims administrator obtain the rights under this provision. If you don't reimburse the claims administrator, the claims administrator may reduce your and your Dependents' future payments under the plan or bring legal action to recover the overpayment.

If the plan has not yet paid benefits relating to an injury or illness that was caused by a third party, the plan may reduce or deny future benefits relating to that injury or illness on the basis that the covered person (or beneficiary) received compensation from the responsible party.

The plan is not required to pay expenses that would be otherwise covered by the plan for past illnesses or injuries that are settled (through judgment, settlement or otherwise). And, the plan's rights of subrogation and reimbursement apply even if the original illness or injury happened before coverage under the plan began.

Administrative Information

Your ERISA Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

Receive Information About Your Plans Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Plan Coverage
You may continue coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

If you have creditable coverage from another plan, you will receive a certificate of coverage that helps to reduce or eliminate exclusionary periods of coverage under your new group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group medical plan or medical insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the claims procedures as described in this SPD. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Discretionary Authority

The plan administrator has discretionary authority to grant or deny benefits under this contract and plan, to interpret the plan language and to determine eligibility. The plan administrator has delegated full discretionary authority involving any benefit determination to the claims administrator. Benefits under the contract and plan will be paid only if the claims administrator decides in its discretion that you, the applicant, are entitled to them. The decision of the claims administrator shall not be overturned unless determined by a court of law to be arbitrary and capricious.

Plan Amendment and Termination

The University has reserved the right, in its sole discretion under circumstances that it deems advisable (including, but not limited to, a need to address cost or plan design considerations), to terminate the Plan or to amend or eliminate benefits. In the event of termination or amendment or elimination of benefits, the rights and obligations of participants prior to the date of such event shall remain in effect, and changes shall be prospective, except to the extent that the University's action and applicable law permit otherwise.

Collective Bargaining

Certain provisions of the Group Medical Insurance plan may be subject to collective bargaining agreements between the University of Chicago and certain unions.

If you are a member of a collective bargaining unit affected by these agreements, you can obtain a copy of the unit's agreement by writing to the plan administrator, or you may obtain it at the Office of Employee and Labor Relations.

Privacy Information

During the administration of the medical plan, the plan and claims administrators may come into contact with what is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA). The University has taken specific steps to protect and limit access to this information. For example, the University has:

- Designated a Privacy Office
- Developed privacy policies and procedures
- Implemented safeguards to protect against improper disclosure
- Provided a complaint resolution process
- Developed sanctions for employees and business partners that violate privacy policies
- Established confidentiality agreements with business associates

As part of our compliance efforts, we must provide a privacy notice to employees. If you would like to review the privacy policies and procedures, receive another copy of the privacy notice or just need more information, please contact the Benefits Department.

Continuing Your Coverage Under COBRA – *Very Important Notice for you and your spouse (if covered) or your Domestic Partner (if covered)*

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act ("COBRA") was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

You are receiving this notice because you are covered under a group health plan. This notice contains important information about your right to COBRA continuation coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your eligible family members, and what you need to do to protect the right to receive it.

Both you and your spouse or your Domestic Partner, if your spouse or Domestic Partner is currently covered under any of the group health plans sponsored by the University, should take the time to read this section of the summary plan description carefully and keep this summary plan description with your records.

Qualified Beneficiaries

If you are an employee of the University, the spouse or a Dependent of the employee and you are covered under a group health plan sponsored by the University, you have an independent right to elect continuation coverage. An eligible Dependent includes a child who is born or placed for adoption with you or your Domestic Partner during the period of continuation coverage under COBRA.

Qualifying Events
Qualified beneficiaries can elect continuation of coverage for any of the reasons outlined below (called "qualifying events"). Different qualifying events apply to different covered groups as follows:

Qualifying Event	You	Spouse or Domestic Partner	Dependent Children	Notification
Your employment with the University ends (except for gross misconduct, in which case COBRA benefits are not available)	X	X	X	Within 44 days after the date coverage would end because of the event (usually, that date is the end of the month in which the event occurs), the **Benefits Office** will notify you and your covered Dependent(s) of the right to continue coverage under COBRA. You and your covered Dependent(s) will have 60 days after notification to make an election and pay the premium. If you do not elect and pay for continuation coverage on a timely basis, your group health plan coverage will terminate.
You are no longer a Benefits-Eligible Employee	X	X	X	
You become eligible for Medicare		X	X	
You die		X	X	
You divorce, legally separate or terminate your Domestic Partnership		X	X	**You or your Covered Dependents(s)** have 60 days after a divorce, legal separation, termination of a Domestic Partnership or when your child loses Dependent status to notify the Benefits Office of the qualifying event. If you or your covered Dependents provide timely notice of these qualifying events, such notice will preserve the COBRA election rights for all Dependents that lost coverage as a result of the qualifying event. Failure to provide such notice in a timely manner may result in loss of the right to elect COBRA continuation coverage. Upon notice of the qualifying event, within 44 days, the Benefits Office will notify you and your covered Dependents, as applicable, of benefit election rights under COBRA. After receiving a notice of benefit election rights, you or your covered Dependents, as applicable, will then each have 60 days to make an election and pay the premium. If you or your Covered Dependents do not elect and pay for continuation coverage on a timely basis, your group health plan coverage will terminate.
Your child loses Dependent status or disability status			X	

Benefits and Costs
The benefits provided under COBRA will be the same as those provided to active employees. However, the University no longer shares the cost with you. The premiums you pay include the full health care cost, plus a 2% administrative fee. The claims administrator will bill you.

When COBRA Coverage Ends
The situations and time limits during which you can continue coverage are shown in the chart below.

Who Can Continue Coverage	In What Situations	For How Long
You and your eligible Dependents	• A reduction in your work hours resulting in a loss of coverage. • Your termination (except for gross misconduct).	18 months
Your eligible Dependents	• Your death. • Divorce, legal separation or termination of Domestic Partner registration. • Eligibility for Medicare.	36 months
Your Dependent child(ren)	• Child(ren) reach age 26. • Military veteran dependent child(ren) reach age 30. • Child(ren) are no longer eligible.	36 months

If you lost coverage because your employment was terminated or your hours were reduced, your and your Dependents' continuation coverage ends after 18 months. If during those 18 months another event takes place that entitles you to continuation coverage, your continuation coverage may be extended up to another 18 months, but in no case can it last more than 36 months.

Continued coverage will end sooner than the time limits shown if:

- You do not pay your premiums by the required due date.
- You or your Dependent(s) become covered under another group plan (except if that plan has a pre-existing condition rule).
- The Dependent enrolls in Medicare.
- The University discontinues medical care coverage for active employees.

Once you cancel your continued coverage, you cannot re-enroll in the University medical plans.

Disability Is a Special Case
If you, your spouse or your eligible Dependents are disabled (as determined by Social Security) at any time during the first 60 days of continuation coverage, the disabled person may be able to continue coverage for up to a total of 29 months from the date of the qualifying event.

To qualify, you must notify the Benefits Office within 60 days of the date Social Security makes its disability determination, and that determination must be made within the first 18 months of continuation coverage. If the disability ends, you (or your disabled Dependent) must notify the Benefits Office within 30 days of the determination. Continued coverage will end on the first day of the month that is 31 or more days after the Social Security determination that the disability has ended.

Trade Act 2002
Certain Individuals who, under limited circumstances, become eligible to take advantage of trade adjustment assistance pursuant to the Trade Act may receive a second 60-day COBRA election

period. If you are receiving trade adjustment assistance or if you are eligible for trade adjustment assistance, please contact the Benefits Office for more information.

Additional Continuation Coverage Information
Your COBRA rights are subject to change. Coverage will be provided only as required by law. This notice is only a general summary of the law, federal and state continuation coverage law and the applicable plan provisions will control over this summary in the event of a conflict. If the law changes, your rights will change accordingly.

If You Have Questions
If you have questions about the plan or your COBRA continuation coverage rights, contact the Benefits Office at:

The University of Chicago
Benefits Office
6054 S. Drexel
Chicago, IL 60637
773-702-9634

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

To protect your family's rights, you should keep the Benefits Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Office.

Other Plan Information

You will need this information for future reference or if you have any questions about your benefits.

Feature	Maroon Plan	HMO Plans
Plan Name	University of Chicago Maroon Medical Plan; also known as the Maroon Plan	University of Chicago Health Plan HMO Illinois Humana Premier HMO Plan
Employer, Plan Sponsor and Administrator	The University of Chicago 6054 S. Drexel Chicago, IL 60637 773-702-9634	
Plan Funding and Administration	The Maroon plan is self-insured. The University and employees jointly pay for the coverage. The University has an administrative services contract with a third-party administrator – the claims administrator.	The HMO Plans are fully insured. The University and employees jointly pay for coverage.

Feature	Maroon Plan	HMO Plans
Agents for Service of Legal Process	Service of legal process may be made on the plan administrator or the appropriate party listed below: The University of Chicago Benefits Office 6054 S. Drexel Chicago, IL 60637 773-702-9634	University of Chicago Health Plan 180 North Harvester Drive Suite 110 Burr Ridge, IL 60527 HMO Illinois, a Blue Cross HMO 1020 West 31st Street Downers Grove, IL 60515-5622 Humana Inc. 500 W. Main Street Louisville, KY 40202
Claims Administrator (Responsible for processing and paying claims, selecting network providers and, in the case of the HMOs, fully insuring plan benefits.)	**Medical Care** Blue Cross/Blue Shield of Illinois 300 E. Randolph Street Chicago, IL 60601 **Prescription Drugs** Caremark 2211 Sanders Road NBT Northbrook, IL 60062	**UCHP** University of Chicago Health Plan 180 North Harvester Drive Suite 110 Burr Ridge, IL 60527 **HMO Illinois** HMO Illinois, a Blue Cross HMO 1020 West 31st Street Downers Grove, IL 60515-5622 **Humana Premier HMO Plan** Humana Inc. 500 W. Main Street Louisville, KY 40202
Utilization Review Organization (Responsible for reviewing the required pre-certification procedures.)	Medical Services Advisory Blue Cross/Blue Shield of Illinois 300 E. Randolph Street Chicago, IL 60601 (866) 390-7772	
Plan Year	January 1 to December 31 The end of the plan year for fiscal record purposes is December 31.	
Employer Identification Number (EIN)	36-2177139	
Plan Number	Welfare (medical) – 510	
Plan Type	Welfare plan providing insured and self-insured medical benefits.	

Glossary

Actively at Work	Performing for wages that are regularly paid by the University, the material and substantial duties of your occupation at the usual place of work or at any alternate place of work required by the University.
Benefits-Eligible Employee	Generally, you are benefits-eligible if you are: • **Full-Time:** your position is anticipated to exist for one year or longer and you are scheduled to work at least 35 hours per week. • **Part-Time:** your position is anticipated to exist for one year or longer and you are scheduled to work 20 - 35 hours per week. You are not benefits-eligible if you are scheduled to work fewer than 20 hours per week or if your position is expected to exist less than one year.
Coordination of Benefits	A provision that prevents duplication of benefit payments when you or your Dependent(s) also have coverage through another group plan. Coordination of Benefits procedures also determines which plan pays first.
Copayment	A flat dollar amount you pay for a specific service.
Coinsurance	The portion of covered medical bills that you pay for necessary care, after you meet your Deductible.
Deductible	The portion of your medical expenses you pay before the plan begins to pay benefits.
Dependent Children	This includes natural, step- and legally adopted children and children placed in the home for adoption. This also includes grandchildren if you or your Domestic Partner is the legal guardian, claims the child for income tax and legal purposes, and lives with the child in a parent/child relationship. Coverage continues up to the child's 26th birthday if he or she is unmarried (30 for military veteran dependents). If you have a mentally or physically disabled child who was covered under the plan before age 26, you can generally continue coverage for that child indefinitely. You are responsible for notifying the Benefits Office when your Dependent child marries or reaches age 26. If you do not, your child may lose his or her coverage, and you may pay for coverage at a higher rate than you should.
Dependents	Include your spouse, Domestic Partner and Dependent Children. The plan does not cover your parents, grandchildren (unless noted in the Dependent Children definition) or foster children. If you have questions about your eligible dependents, contact the Benefits Office.
Domestic Partners	Two individuals of the same gender who live together in a long-term relationship of indefinite duration, with an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. The partners may not be related by blood to a degree that would prohibit legal marriage in the state in which they legally reside and may not be married to any other person. Your Domestic Partner must be registered with the Benefits Office. Certain restrictions may apply if your Domestic Partner is not an Internal Revenue Code Section 152 Dependent.
Full-Time	Your position is anticipated to exist for one year or longer and you are scheduled to work at least 35 hours per week.

Home Health Care Agency	An agency or organization that provides a program of home health care and is either approved by Medicare, or is established and operated in accordance with licensing and laws and: • Primarily be for providing skilled nursing and other therapeutic services in the home. • Have policies established by one or more physicians and one or more registered graduate nurses to govern the services provided under the supervision of a physician or nurse. • Have a full-time administrator. • Maintains written medical records of services to patients. • The staff includes at least one registered graduate nurse or care by such nurse is available. • Employees are bonded and it provides malpractice and malplacement insurance.
Hospital	A facility (other than a rest home, resort, nursing home, convalescent home, place for custodial care or home for the aged) that provides medical care and treatment of the sick and injured on an inpatient basis. The facility must be accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations; a Hospital, psychiatric Hospital or tuberculosis Hospital as defined by and eligible under Medicare; or provides operative surgery on the premises, continuously provides 24-hour nursing service supervised by a registered graduate nurse and maintains treats sick and injured under the supervision of a qualified physician.
Lifetime Maximum	The most each covered person can receive from the medical plan.
Medically Necessary Care	A specific health care or Hospital service that is necessary for the treatment or management of a medical symptom or condition, and is the most efficient and economical care that can be safely provided.
Out-of-Pocket Limit	A cap on how much you have to pay for your family's covered medical expenses in a calendar year. After you reach the Out-of-Pocket Limit during a calendar year, the plan pays 100% of the rest of all covered expenses for that year.
Part-Time	Your position is anticipated to exist for one year or longer and you are scheduled to work 20 - 35 hours per week.
Primary Care Physician (PCP)	Manages all of your health care needs, including referrals to participating specialists.
Qualifying Change in Family Status	The specific situations when you may change your coverage level after Open Enrollment.
Prevailing Fee Schedule	The amount in-network professional providers in your area generally charge for a specific service.
Reasonable and Customary Charges	The amount facility providers in your area generally charge for a specific service.
Skilled Nursing Facility	A Skilled Nursing Facility that is eligible to receive payments under Medicare (except for a Skilled Nursing Facility that is part of a Hospital). Also includes an institution or distinct part of an institution that is operated in accordance with applicable laws; regularly engages in providing continuous 24-hour a day care under the supervision of a licensed physician during the post-acute and rehabilitative state of an injury or illness; maintains daily medical records for each patient; is authorized to administer medication to patients; and is not primarily a home for the aged, a hotel, a school, a custodial care facility or an institution for treatment of substance abuse or mental illness.

A Final Note

This summary is written in everyday language, provides a general summary of the plan in effect on January 1, 2006 and serves as your summary plan description. We have tried to make it as complete and accurate as possible. If there are any discrepancies between this summary and the formal plan documents, such as the certificate of insurance, those documents will determine how the plan works and the benefits that are paid. The University has the authority to interpret the terms of the plan and to address questions arising under the plan and may delegate some or all of this authority to other entities, such as insurance companies or claims payors. The insurance carrier makes determinations of benefits under its certificate of insurance.

The University intends to continue this plan indefinitely, but reserves the right to amend or terminate it at any time for any reason. Please keep in mind that health plan benefits do not vest. Participating in this plan does not guarantee employment.

Benefits under this plan will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them.

Please keep in mind, while the plan only covers specific services and treatment, you and your Dependents always have the choice of what services you receive and who provides your health care (but you may have to pay for it). Neither the plan nor the University ensures the quality of care you receive and only the claims administrators are involved in the selection of network providers.