



THE UNIVERSITY OF
CHICAGO

The University of Chicago

Health Care Plans Summary Plan Description

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Introduction to the University of Chicago Health Care Plans Summary Plan Description

This document, together with the coverage booklets or certificates, as applicable, of each Benefit Program offered under the University of Chicago Health Care Plans (the "Plan"), constitutes the Summary Plan Description ("SPD") required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The SPD contains information regarding the eligibility requirements, benefits, coverage options, and many other features of the Plan and underlying Benefit Programs. You should take the time to read the SPD to get a better understanding of your rights and obligations under the Plan.

If this SPD does not answer all of your questions, please contact the Plan Administrator or other Plan representative. The Plan Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name and address of the Plan Administrator can be found on Page 33.

The SPD describes the Plan's benefits and obligations as contained in the legal plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language and is intended to comply with applicable legal requirements. If the non-technical language in this SPD and the language of the Plan document conflict, the Plan document always governs. To the extent of any conflict between a Benefit Program document and this document, the Plan document will control. If you wish to receive a copy of the legal Plan document, please contact the Plan Administrator.

The Plan and your rights under the Plan are subject to federal laws, such as ERISA and the Internal Revenue Code (the "Code"), as well as some state laws. The provisions of the Plan are subject to revision due to changes in the law or due to pronouncements by the Internal Revenue Service (the "IRS") or U.S. Department of Labor ("DOL"). The University may also amend or terminate the Plan or any Benefit Program at any time in its discretion. If the provisions of the Plan that are described in this SPD change, the Plan Administrator will notify you.

You can obtain additional information about the Benefit Programs by visiting the University's Benefits website at <https://humanresources.uchicago.edu/benefits/healthwelfare/index.shtml>, or by contacting the University Benefits Office at 773.702.9634 or benefits@uchicago.edu.

Eligibility

Employee Eligibility

You are eligible to participate in the Plan if you are a common-law employee of the University and:

- You are scheduled to work at least 20 hours per week, or
- The University determines you are a “full-time employee” under the Affordable Care Act.

Your eligibility for each Benefit Program is governed by the terms of the applicable Benefit Programs. See the applicable Benefit Program document for more information.

Ineligible Persons. The following individuals are not eligible to participate in the Plan:

- Independent contractors
- Leased employees
- Employees of University affiliates (unless the affiliate has adopted the Plan)
- Student workers
- Patient actors employed by the Biological Sciences Division
- University police employees classified as non-benefits eligible
- Laboratory Schools substitute teachers
- Teachers/instructors without an academic appointment at the Graham School
- Employees of the Court Theatre employed for specific productions of the theater
- Union employees whose collective bargaining agreement excludes the employee from participation in the Plan
- Employees in non-benefits eligible positions

If you are in a class of individuals who are not eligible to participate in the Plan, you are not eligible to participate in any Benefit Program offered under the Plan.

Retiree Eligibility

You are eligible to participate in the Plan as a retiree if:

- You were hired by the University prior to January 1, 2005, were at least age 55 on the date you retired or your employment with the University ended, and were continuously employed by the University from your hire date to your termination date in a “Benefits-Eligible” position (see below).
- You were employed by the University on or after January 1, 2005 and were at least age 55 and had completed at least 10 years of continuous service with the University in a Benefits-Eligible position on the date you retired or your employment with the University ended.

For the Retiree Medical Plan, “**Benefits-Eligible**” positions are the following positions with the University:

- Full-time or half-time faculty member
- Full-time or half-time non-faculty academic appointee
- Full-time or half-time officer
- Full-time post-doctoral scholar
- Full-time teacher at the Laboratory Schools
- Non-academic employee scheduled to work at least 20 hours per week

For the Retiree Medical Plan, the following positions are not considered “Benefits-Eligible” positions:

- Student workers
- Patient actors employed by the Biological Sciences Division
- University police employees classified as non-benefits eligible
- Laboratory Schools substitute teachers
- Teachers/instructors without an academic appointment at the Graham School
- Collectively bargained employees
- Employees with agreements that provide that they are non-benefits eligible
- Employees of the Court Theatre employed for specific productions of the theater
- Faculty, non-faculty academic appointees, officers, post-doctoral scholars, or Laboratory School teachers whose appointment is unpaid

Your eligibility for benefits under the Plan is governed by the terms of the Retiree Medical Plan document and the applicable Benefit Programs.

Employees on Long Term Disability

You are eligible to participate in the Plan if you are disabled, as determined by your physician, and, as of the date of your disability, you are enrolled in the Plan or can provide proof of other medical, dental, or vision coverage (as applicable) as of the date of your disability. You are eligible only to participate in the type of Benefit Program (medical, dental, and/or vision) that you were enrolled in as of the date of your disability.

Dependent Eligibility

If you are an eligible employee who enrolls in the Plan, you also may enroll your eligible Dependents. The following individuals are eligible “Dependents” under the Plan:

- Your legal spouse *OR* your civil union partner *OR* your registered domestic partner (registered with the University on or before December 31, 2016), and
- Your Dependent children, who generally are:
 - Your natural children, stepchildren, and legally adopted children or children placed for adoption with you (and the natural children, stepchildren, and legally adopted

- children of, or children placed for adoption with, your legal spouse or civil union partner), if they are younger than age 26;
- Your registered domestic partner's unmarried natural children and legally adopted children who are younger than age 26 are also eligible Dependents if you and your registered domestic partner provide at least 50% of the child's support and the child is living with you;
 - Your (or your spouse's or civil union partner's) unmarried natural children, stepchildren, and legally adopted children who are younger than age 30 and residents of Illinois, who served in the U.S. Armed Forces (active or reserve) and did not receive a dishonorable discharge;
 - Your registered domestic partner's unmarried natural children, stepchildren, and legally adopted children who are younger than age 30 and residents of Illinois, who served in the U.S. Armed Forces (active or reserve) and did not receive a dishonorable discharge are also eligible Dependents if you and your registered domestic partner provide at least 50% of the child's support and the child lives with you;
 - Your unmarried ward (or ward of your spouse, civil union partner, or registered domestic partner) who is younger than age 18, if you (or your spouse, civil union partner, or registered domestic partner) are the ward's legal guardian, provide at least 50% of the ward's support, and the ward is living with you;
 - Your unmarried natural children, stepchildren, or legally adopted children (and the natural children, stepchildren, or legally adopted children of your spouse, civil union partner, or registered domestic partner) of any age, who become incapable of self-sustaining employment due to disability prior to age 26, and who were covered under the applicable Benefit Program on their 26th birthday, if you provide at least 50% of the child's support, and the child is living with you (and have been continuously covered under the medical, dental, and/or Benefit Program, as applicable); and
 - Any child required to be covered under either a qualified medical child support order or a national medical support notice.

Your Dependent's eligibility for each Benefit Programs is governed by the terms of the applicable Benefit Programs. See the applicable Benefit Program document for more information.

The University has the right to request, at reasonable intervals, proof that an individual meets the criteria of an eligible Dependent and to deny coverage/benefits to anyone who does not satisfy the criteria.

Enrollment

Participation in the Benefit Programs is optional. You may enroll yourself and your eligible Dependents in a Benefit Program:

- As a newly hired or re-hired eligible Employee, by submitting your election within the 31-day period following your first day of employment;
- As a newly eligible Employee, by submitting your election within the 31-day period following the date you first become eligible to participate in the Plan.
- During the annual enrollment period each year, by following the process outlined in the annual enrollment materials; or
- Within the 31-day period (or longer period, if required by law) following a Change in Status.

In most cases, you must submit your enrollment or change enrollment elections via the University Workday website (workday.uchicago.edu).

See the section titled “**Retiree Medical Plan Enrollment**” below for special rules applicable to enrollment in the Retiree Medical Plan Benefit Program.

Changing Your Enrollment

You may elect to change your elections under the Plan during the annual open enrollment period. Any changes you make will take effect the following January 1 after the annual open enrollment period.

You may make changes to your elections under the Plan only during the annual open enrollment period, unless you have a Change in Status and request to make an enrollment change that is consistent with the Change in Status.

A Change in Status includes, but is not necessarily limited to:

- Your marriage, divorce, legal separation or annulment (including to/from civil union partner)
- The death of your spouse or civil union partner
- A change in your registered domestic partner status
- The birth, adoption, or placement for adoption of a child
- A change in the number of your eligible Dependents
- A change in your employment status or that of your spouse or eligible Dependents (including a change in worksite, a strike or lockout, or termination or commencement of employment)
- A change in your residence or that of your eligible Dependent
- A change that causes your Dependent to satisfy or cease to satisfy the eligibility requirements under the Plan

- A loss of coverage by you or your eligible Dependents under a governmental or educational institution's group health plan, Medicaid or CHIP
- A significant change in your premium under a Benefit Program
- A significant change in coverage under a Benefit Program
- A change in coverage under another employer plan
- You or your eligible Dependent becoming entitled to Medicare or Medicaid (or losing eligibility for Medicare or Medicaid)
- The issuance of a judgment, decree or court order resulting from a divorce, legal separation, annulment, or change in legal custody that requires you to provide health coverage for your eligible Dependent.

Any change you request due to a Change in Status must be consistent with the change in your status, as determined by the Plan Administrator. The Plan Administrator reserves the right to modify your election to the extent necessary to comply with a qualified medical child support order or similar order, to comply with applicable law, or for such other reasons that are permitted by law and the Plan document.

Retiree Medical Plan Enrollment. You may enroll yourself and your eligible Dependents in the Retiree Medical Plan Benefit Program:

- Initial Enrollment. Within the 31-day period following the date you retire from the University or the date your employment with the University terminates, if you pay any past-due premiums under the Plan within that period. You and your eligible Dependents must be enrolled in Medicare Part A and Part B (if eligible).
- Postponed Enrollment. Within the 31-day period following the date you lose other group health coverage or Medicaid coverage, if, within 31 days of the date you retired from the University or the date your employment with the University terminated, you made an election to postpone your enrollment in the Retiree Medical Plan, paid any past-due premiums under the Plan, and provided proof of coverage under another group health plan. You and your eligible Dependents must be enrolled in Medicare Part A and Part B (if eligible).

Upon enrollment in the Retiree Medical Plan, or upon reaching age 65 if you are already enrolled in the Plan, you are automatically enrolled in the Medicare Part D prescription drug program administered by Express Scripts.

If you do not enroll in the Retiree Medical Plan during the times described above, you will not be eligible for the Plan and will not be allowed to enroll in the Plan at a later date.

You may also enroll an eligible Dependent in the Retiree Medical Plan Benefit Program during the 31-day period following:

- Your marriage or civil union;
- Your acquisition of an eligible Dependent (for example, through birth, adoption, marriage); or

- A loss of coverage under a group health plan by your spouse, civil union partner, or eligible Dependent.

You may enroll an eligible Dependent in the Retiree Medical Plan Benefit Program during the 60-day period following if you, your spouse, civil union partner, or eligible Dependent become eligible for or lose coverage under Medicaid or CHIP.

When Coverage Begins

If you submit a timely election as described above, your enrollment in the Plan will take effect as follows:

- As a newly hired or re-hired Employee, your participation takes effect on your first day of employment.
- As a newly eligible Employee, your participation takes effect on the date you become an Eligible Employee.
- During the annual open enrollment period, your participation will take effect January 1 of the next following calendar year.
- Upon a Change in Status, your participation takes effect on the date of the Change in Status.

Note: Employee pre-tax contributions towards Plan premiums are subject to IRS Section 125 cafeteria plan rules. Accordingly, payment of your Plan premiums on a pre-tax basis begins no earlier than the date of your election (with exceptions for certain Changes in Status).

If you do not enroll within the required election period following your hire or re-hire, or upon first becoming eligible for the Plan, you will not be covered under the Plan or any of the Benefit Programs for the remainder of the calendar year unless you experience a Change in Status consistent with an allowable change in enrollment.

If you do not change your election during an annual open enrollment period, your most recent election will remain in effect for the next calendar year.

When Retiree Medical Plan Coverage Begins. As a retiree, your participation in the Retiree Medical Plan will take effect as specified in the Retiree Medical Plan enrollment materials.

When Coverage Ends

Your coverage and the coverage of your Dependents will end as described below. However, you and your eligible Dependents may be eligible to continue Plan coverage under COBRA (see page 14).

Employees. Your coverage under the Plan (or Benefit Program, as applicable) will end at 11:59pm on the earliest of the following:

- The date that the University discontinues or terminates the Plan or Benefit Program.
- The last day of the month that you cease to be an eligible Employee.
- The last day of the month that you elect to discontinue participation in the Plan or Benefit Program.
- The last day of the month for which you pay your required premium if you fail to pay your required premium when due.

Retirees. Your coverage under the Retiree Medical Plan will end at 11:59pm on the earliest of the following:

- The date that you elect to discontinue participation in the Retiree Medical Plan.
- The date that you die.
- The last day of the month for which you pay your required premium if you fail to pay your required premium when due.
- The date the University terminates the Plan or the Retiree Medical Plan.
- The date the University ceases coverage under the Plan for your class of former employees.
- The date immediately prior to the day you are rehired as a benefit-eligible employee of the University.

Participants on Long Term Disability. Your coverage under the Plan (or Benefit Program, as applicable) will end at 11:59pm on the earliest of the following:

- The last day of the month that preceded the date that you are no longer receiving benefits under the University's long-term disability plan.
- The last day of the month in which you terminate your enrollment in the Benefit Program.
- The last day of the month for which you pay your required premium if you fail to pay your required premium when due.

Dependents. Coverage of your eligible Dependent under the Plan (or Benefit Program, as applicable), will end at 11:59pm on the earliest of the following:

- The date that the University discontinues or terminates the Plan or Benefit Program.
- The last day of the month that your eligible Dependent ceases to be an eligible Dependent.
- The last day of the month that you (or your eligible Dependent) elect to discontinue your eligible Dependent's participation in the Plan or Benefit Program.
- The last day of the month in which you die (except for surviving spouse following your death).
- The last day of the month for which you pay the required premium for eligible Dependent coverage if you fail to pay your required premium when due.

- The last day of the month that your coverage under the Retiree Medical Plan ends (except for surviving spouse following your death).

The Plan Administrator reserves the right to terminate your coverage under the Plan as well as the coverage of your eligible Dependents, and take other appropriate action if you or your eligible Dependent:

- provide false information to the Plan in connection with enrollment in or ongoing participation,
- allow an individual who is not covered under the Plan to falsely obtain benefits under the Plan, or
- attempt to obtain benefits under the Plan by means of false, misleading or fraudulent information, acts or omission.

Benefit Programs

The following Benefit Programs are available under the Plan:

Medical Benefit Programs

- Maroon Plan
- Maroon Savings Choice
- The University of Chicago Health Plan
- HMO Illinois Plan
- BlueCross BlueShield of Illinois PPO for Post-Doctoral Scholars and Fellows
- BlueCross BlueShield of Illinois HMO for Post-Doctoral Scholars and Fellows
- CIGNA Global Plan

Dental Benefit Programs

- MetLife Dental PPO Plan
- MetLife Dental CoPay Plan
- Principal Dental PPO Plan for Post-Doctoral Fellows

Vision Benefit Programs

- Base Plan
- Premier Plan
- VSP Voluntary Vision Plan for Post-Doctoral Scholars and Fellows

Retiree Benefit Programs

- The University of Chicago Retiree Medical Program

Your Plan coverage/benefits may be affected by your eligibility for Medicare. See the annual open enrollment materials for more information.

For a detailed description of the benefits available under each Benefit Program, refer to the Benefit Program's benefit booklet or certificate of coverage, available online at <https://humanresources.uchicago.edu/benefits/healthwelfare/index.shtml> or by contacting the Benefits Office at 773.702.9634 or benefits@uchicago.edu.

Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you, your spouse, and your Dependent child(ren) may elect to temporarily continue health care coverage under the Plan if coverage ends because of a Qualifying Event as described in this section. To be eligible for continued coverage, you must be enrolled in the Plan when the coverage would otherwise end as a result of the Qualifying Event. In addition to you, your spouse, and any Dependent child(ren) covered at the time of a Qualifying Event, any child who is born to you, adopted by you, or placed for adoption with you during COBRA coverage is also eligible for coverage. **The following procedures will apply unless the applicable Benefit Program specifies terms of continuation coverage. See the applicable Benefit Program coverage booklet for more information.**

Right to Elect Continuation Coverage

Generally, you, your spouse, and your Dependent children can elect to continue plan coverage for up to **18 months** if Plan coverage would otherwise end because of one of the following reasons, called "Qualifying Events:"

- voluntary termination of your employment;
- involuntary termination of your employment for reasons other than gross misconduct; or
- change of your employment status due to a reduction in hours.

Your spouse and any Dependent children can elect to continue coverage for up to **36 months** if their Plan coverage would otherwise end because any of the following "Qualifying Events" occur:

- your death;
- your divorce;
- your legal separation;
- your entitlement to Medicare benefits; or
- the failure of your Dependent child to qualify as a "Dependent" under the Plan.

In some cases, a Qualifying Event may permit your spouse and your Dependent children to elect continued coverage for 18 months, and, during that 18-month period, a second Qualifying Event occurs that would permit your spouse and Dependent children to elect coverage for up to 36 months. Your spouse and Dependent children may then elect to continue coverage for an additional 18-month period, for a maximum of 36 months after the original Qualifying Event, if notice of the second Qualifying Event is properly given to the Plan Administrator or its delegate within 60 days of the occurrence of such event, along with any required documentation. See the "Notices" section below for a discussion of the required notice procedures. For example, suppose you stop working for the University and you, your spouse, and your Dependent children elect continued coverage. Coverage would normally continue for 18 months. However, during that 18-month period, you and your spouse divorce. Upon proper written notice to the

Plan Administrator or its delegate within 60 days of the divorce, your spouse and Dependent children may elect continued coverage for an additional 18-month period, for a maximum total period of 36 months from the time your employment with the University ended. However, Medicare entitlement that occurs after termination of employment will not cause an extension of COBRA by 18 months.

If your employment terminates or work hours are reduced within 18 months after entitlement to Medicare, your spouse and Dependent children may continue coverage for up to 36 months from the date you become entitled to Medicare. However, if your employment terminates or work hours are reduced more than 18 months after your entitlement to Medicare, your spouse and Dependent children may continue coverage for up to 18 months from the date your employment ended or your work hours were reduced.

Election Period

You will have at least 60 days within which to decide whether to continue coverage under the Plan, beginning no later than the date your coverage would otherwise terminate due to a Qualifying Event. The Plan Administrator or its delegate must receive your written election within 60 days from the later of:

- the date your coverage would otherwise terminate due to a Qualifying Event, or
- the date the Plan Administrator or its delegate notifies you of your continuation rights because of a Qualifying Event.

Notices

The Plan Administrator or its delegate will notify you if you become entitled to elect to continue your Plan coverage. However, you and your family must notify the Plan Administrator or its delegate within 60 days in the event of divorce, legal separation, or when a child no longer qualifies as a covered dependent under the Plan. You must provide this notice in writing, by e-mail, or by fax to the Plan Administrator or its delegate. Failure by you or your family to timely provide proper notice will result in ineligibility to continue or extend coverage, as applicable.

Type of Coverage

If you are eligible for continuation coverage, you may elect to continue the type of coverage under the Plan that was in force immediately before the Qualifying Event. Your coverage will be the same as the coverage that is provided to similarly-situated individuals who have not experienced a Qualifying Event. You will not be required to give evidence of good health in order to continue coverage. In addition, during an open enrollment period, you will have the same rights to choose among coverage options (with respect to the benefits for which you have previously elected to continue coverage) as the rights that are available to similarly-situated individuals who have not experienced a Qualifying Event.

Cost of Continued Coverage

You must pay the full cost of continued coverage, plus 2% to cover administrative costs. If you decide to continue coverage after the date your coverage would otherwise terminate, the Plan

Administrator or its delegate must receive your payment for your retroactive coverage within 45 days from the date of your election.

At that time, you may have to pay for the following:

- coverage during the 60-day election period; and
- coverage during the 45-day payment period following that date.

After that, regular monthly payments for coverage will be due on or before the first day of each month. Payment must be received no later than 30 days after the first day of the month for which the premium is owed.

Disabled Participants

If the Social Security Administration determines, within 60 days of the date that COBRA continuation coverage began due to a change in employment, that you, your covered spouse, or your covered Dependent child is/are disabled, you and your family members who are entitled to COBRA continuation coverage can request an extension of the maximum coverage period from 18 to 29 months. To obtain this extended coverage, the Plan Administrator or its delegate must be notified of the Social Security Administration's disability determination within 60 days of the determination and prior to the end of the initial 18-month period. You must provide this notice in writing to the Plan Administrator or its delegate. The notice must contain a description of the Qualifying Event, the date of occurrence of the event, and the names of all family members whose coverage may be affected by the occurrence of such event. You are required to include with your notice a copy of the determination letter from the Social Security Administration. Failure by you or your family to timely provide such notice will result in ineligibility to obtain extended coverage.

Disabled individuals and their family members with extended coverage must pay 102% of the full cost of their continuation coverage for the first 18 months. After 18 months, the required payments will increase from 102% to 150% of the full cost of coverage if the disabled individual is covered.

If the Social Security Administration later determines that the individual is no longer disabled, you must notify the Plan Administrator or its delegate within 30 days of the determination. Termination of COBRA coverage for this reason will occur as of the first day of the month beginning more than 30 days after the date of the final determination.

Continuation Coverage for Newly-Acquired Dependent Children

If, while your coverage is being continued under COBRA, a child is born to or placed for adoption with you, you may elect coverage for the newly-acquired Dependent under the same provisions in effect for similarly-situated active employees if you:

- notify the Plan Administrator or its delegate of the birth or adoption of the child within 30 days of the birth or adoption; and
- pay the required premium.

You must provide notice of the birth or adoption, and any other documentation the Plan Administrator may require, in writing, by email, or by fax to the Plan Administrator or its delegate. Failure to timely provide proper notice will result in ineligibility to obtain such coverage.

If a second Qualifying Event occurs for a newly-acquired Dependent child that is added to coverage during the period of COBRA continuation coverage, the child may be eligible for coverage for up to 36 months from the date of the original Qualifying Event.

Termination of Continued Coverage

Continued coverage for any covered person will be terminated and cannot be reinstated if:

- the maximum coverage period (18, 29 or 36 months) is reached;
- COBRA premium payment is not received on a timely basis;
- the person becomes covered by another group plan, but only if that Plan does not limit or exclude coverage for any preexisting condition of the person;
- the person becomes entitled to Medicare; or
- the Plan is terminated.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Continuation Coverage for Civil Union and Domestic Partners

While COBRA coverage applies only to your spouse and your Dependent children (including newborns and children adopted by or placed for adoption with you during your COBRA continuation period), the University will make available continued coverage similar to COBRA coverage for your civil union partner or registered domestic partner of time if:

- Your registered domestic partner no longer meets the eligibility requirements under the Plan;
- You no longer meet the eligibility requirements under the Plan;
- Your employment with the University ends; or
- You die.

To be eligible for continuation coverage, your civil union partner or registered domestic partner must be covered under the Plan at the time of the Qualifying Event. The cost of the continuation coverage for your civil union partner or domestic partner and their eligible Dependent children will be the same as the COBRA cost. Premiums will be paid on an after-tax basis and will equal the full cost of continued coverage, plus a 2% fee to cover administrative costs (up to 150% for coverage under an extension due to disability).

If you die while continuing your own coverage under COBRA, your civil union partner or domestic partner may continue the coverage for the remainder of the coverage period.

Keep the Plan Informed of Address Changes

In order to protect your rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Claims Procedures

The following procedures will apply unless the applicable Benefit Program specifies claims procedures. **If the applicable Benefit Program summary, benefits booklet, certificate of coverage or other document specifies claims procedures, those procedures will apply to your claim and you should reference those claims procedures for information about filing and appealing claims under the Plan.** In all cases, the Claims Administrator will administer claims in accordance with Section 503 of ERISA and the regulations issued thereunder.

Filing a Claim

Claims must be submitted to the appropriate Claims Administrator within one year of the date the expense was incurred. Claims for benefits under the Plan must be made on a form provided for that purpose, or in any other manner specified, by the Claims Administrator. If no Claims Administrator has been appointed, the Plan Administrator or its delegate shall be the Claims Administrator.

You may authorize a representative to act on your behalf in pursuing a benefit claim or an appeal of an adverse benefit determination. However, the Plan may establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. In the case of a claim involving urgent care (please see the section below entitled "Urgent Care Claims" for a definition of "urgent care"), a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative. A "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services, consistent with state law. References to "you" in these claims procedures includes your authorized representative where required by law.

Initial Claim Determinations

The procedures for determining your claim depend on whether your claim is an urgent care claim, concurrent care claim, pre-service claim or post-service claim. The information and procedures for deciding each type of claim is provided below. Claims related to eligibility or enrollment in a Benefit Program are described in the section below titled "Claims Procedures for Enrollment Eligibility."

Urgent Care Claims. An urgent care claim is any claim for medical care or treatment for which the Plan's terms require you to obtain advance approval of the benefit prior to obtaining medical care and for which applying the time periods for making non-urgent care determinations (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim involves urgent care is a determination that will be made by a person acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, the Plan will treat a claim as an urgent care claim when a physician with knowledge of your medical condition determines that the claim is a claim involving urgent care under the meaning of this paragraph.

In the case of a claim involving urgent care, you will be notified of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Claims Administrator receives the claim, unless you fail to provide sufficient information to allow the Claims Administrator to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, you will be notified as soon as possible, but not later than 24 hours after the Claims Administrator receives the claim, of the specific information necessary to complete the claim. You will have 48 hours to provide the specified information. You will be notified of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Claims Administrator's receipt of the specified information, or (2) the end of the period afforded to you to provide the specified additional information.

Pre-Service Claims. A pre-service claim is any claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, you will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification will be provided to you as soon as possible, but not later than five (5) days following the failure, except that in the case of a failure to file a claim involving urgent care, the notification will be provided to you within 24 hours. Notification may be oral, unless you request written notification. This paragraph will only apply to failures to follow the Plan's procedures if the failure is a communication (1) by you that is received by a person or department that is usually responsible for handling benefit matters and (2) that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

In the case of a pre-service claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Claims Administrator receives the claim. This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator determines such an extension is necessary due to matters beyond the control of the Claims Administrator and that you are notified, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from the receipt of the notice to provide the specified information.

Post-Service Claims. A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim (see the preceding section for the definition of "pre-service claim") or urgent care claim. In the case of a post-service claim, the Claims Administrator will notify you in writing of any adverse benefit determination within 30 days after receipt of the claim. This period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator determines such an extension is necessary due to matters beyond the control of the Claims Administrator and you are notified, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected. If such an extension is necessary due to your failure to submit the information

necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice to provide the specified information.

Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination), before the end of the period of time or number of treatments, will constitute an adverse benefit determination. You will be notified of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(2) Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and you will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Claims Administrator, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notification of Adverse Benefit Determination

If the Plan denies your claim, in whole or in part, it will provide you with written or electronic notification of an adverse benefit determination (unless oral notification is permitted by law).

The notification will contain the following information:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an appeal of an adverse benefit determination.

For claims under the medical Benefit Programs offered under the Plan, the notification will also contain the following:

- if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Claims Administrator relied upon in making the adverse determination, or a statement that a copy of the rule, guideline, protocol, or other similar criterion was relied upon and will be provided free of charge to you upon request;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.

In the case of any adverse benefit determination concerning an urgent care claim, the notification of benefit determination will include a description of the expedited review process applicable to such claims. Also, in the case of an adverse benefit determination concerning an urgent care claim, the information set out in this section may be provided to you orally, provided that a written notification that meets all the requirements of this section is furnished to you not later than three (3) days after the oral notification.

Appealing an Adverse Benefit Determination

In General You may bring a civil action under Section 502(a) of ERISA only after exhausting your administrative remedies under the Plan, as described in this section, "Appealing an Adverse Benefit Determination." You can appeal an adverse benefit determination and have your claim reviewed by submitting a written request to the Claims Administrator. You will have 180 days from the date you are notified of the denial to appeal your claim. Your appeal must be submitted in writing and include the reasons why you believe the claim to be valid and why it should not be denied.

The term "adverse benefit determination," as it is used in these claims procedures, means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan. An adverse benefit determination also includes a (1) denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be

experimental or investigational or not medically necessary or appropriate and (2) a cancellation or discontinuance of coverage under the applicable plan that has retroactive effect.

You may submit written comments, documents, records, and other information relating to the claim for benefits, and these comments, documents, records, and other information will be taken into account without regard as to whether they were submitted or considered in the initial benefit determination.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information is relevant to a claim for benefits if the document, record, or information:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether the document, record, or information was relied upon in making the adverse benefit determination;
- demonstrates compliance with the administrative processes and safeguards that ensure and verify that benefit claim determinations are made in accordance with governing Plan documents and, where appropriate, the Plan provisions have been applied consistently to similarly-situated claimants; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

If a fiduciary committee or board is responsible for deciding your claim appeal, you will be notified of the Plan's appeal determination within a reasonable period of time, but not later than the date of the meeting of the committee or board that immediately follows the Claims Administrator's receipt of your appeal, unless you file the appeal less than 30 days before the date of the meeting, in which case the appeal determination will be made no later than the date of the second meeting following the Claims Administrator's receipt of your claim appeal. This period may be extended one time by the Plan until the third meeting of the committee or board following the Plan's receipt of your appeal if the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If an extension of time is required, you will be notified in writing prior to the beginning of the extension. The notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination, which will be no later than five (5) days after the date the committee or board makes a determination about your appeal.

The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal of any adverse benefit determination that is based on medical judgment, including determinations with regard to whether a particular treatment, drug, or other

item is experimental, investigational, medically necessary, or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment (see the section entitled "Filing a Claim" for a definition of "health care professional").

The Claims Administrator will provide you, free of charge and before the Plan issues a decision on your appeal, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator must provide you notice of the Plan's determination of your appeal, to give you a reasonable opportunity to respond prior to that date. If the decision of your appeal is based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the new or additional rationale, which must be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator must provide you notice of the Plan's determination of your appeal to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the period for providing notice of the Plan's determination of your appeal will be tolled until such time as you will have had a reasonable opportunity to respond. After you respond or have had a reasonable opportunity to respond but fail to do so, the Claims Administrator will notify you of the Plan's determination of your appeal as soon as the Claims Administrator, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies.

The Claims Administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination. Any health care professional who is engaged for purposes of a consultation for deciding an appeal of an adverse benefit determination that involves medical judgment will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination, nor the subordinate of such individual.

Appeal of Urgent Care Claim Denials. An urgent care claim is eligible for an expedited review process. You may submit an appeal of an urgent care claim orally (e.g., by phone) or in writing. All necessary information, including the appeal decision, will be transmitted between you and the Claims Administrator by telephone, fax, or other available, similarly-expeditious method. You will be notified of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt by the Claims Administrator of your request for review of an adverse benefit determination.

Appeal of Pre-Service Claims. A pre-service claim is any claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. In the case of the appeal of a pre-service claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Claims Administrator receives the claim.

Appeal of Post-Service Claims. A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim (see the preceding section for the definition of "pre-service claim") or urgent care claim. In the case of a post-service claim, the Claims Administrator will notify you in writing of any adverse benefit determination within 60 days after receipt of the claim by the Claims Administrator.

Notification of Appeal Determination

The Claims Administrator will provide you with written or electronic notification of the Plan's determination of your appeal. In the case of an adverse benefit determination, the notification will set forth:

- the specific reason or reasons for the adverse appeal determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits (see the section above entitled "Appealing an Adverse Benefit Determination" for an explanation of which documents, records, and information are considered relevant to your claim); and
- a description of any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures and a statement of your right to bring an action under Section 502(a) of ERISA.

For claims under the medical Benefit Programs offered under the Plan, the notification will also contain the following:

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse appeal determination, you will be provided with either the specific rule, guideline, protocol, or criterion, or a statement that such rule, guideline, protocol, or criterion was relied upon in making the adverse appeal determination and that a copy of the rule, guideline, protocol, or criterion will be provided to you free of charge upon request;
- if the adverse appeal determination is based on medical necessity or an experimental treatment or similar exclusion or limit, you will be provided with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Calculation of Time Periods

For purposes of claim determinations, the period of time within which a determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a determination accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the determination will be suspended from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Claims Procedures for Enrollment Eligibility

You must request a review within 60 days after being notified by the Plan Administrator that your enrollment in the Plan or a Benefit Program has been denied. Your request must be in writing and may include written comments, documents, records, and other information relating to your claim. You may review all pertinent documents and upon request will have reasonable access to copies of all documents, records, and other information relevant to your claim.

The Claims Administrator will notify you of its determination within 60 days of the receipt of your claim. The Claims Administrator may extend its time to review your claim for up to 60 days if the Claim Administrator determines that special circumstances require an extension of time. The Claims Administrator will provide you with notice of any extension and the date by which it expects to render a decision.

Right to Request External Review

You may request external review of an adverse benefit determination under a medical Benefit Program benefit by filing a request for external review within four (4) months after the date you receive notice of a final adverse benefit determination. The request for external review must be made in writing to the Claims Administrator.

Standard External Review

Within five (5) business days following the date the Claims Administrator receives your external review request, the Claims Administrator will perform a preliminary review of the request to determine whether the claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- you were not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, you were not covered under the Plan at the time the health care item or service was provided;
- the adverse benefit determination is based on the fact that you were not eligible for coverage under the Plan (except where the claim relates to a rescission of coverage);
- you have not exhausted the Plan's internal appeal process; or
- you have not provided all the information and forms required to process an external review.

You will be notified of the results of the preliminary review within one (1) business day after completion of the preliminary review. If your request is incomplete, the notice will describe the information, materials, etc. needed to complete the request, and set forth the time limit for you to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, 48 hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

Expedited External Review

Expedited external review may be requested when:

- an adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize your life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- a final internal adverse benefit determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize your life, health, or ability to regain maximum function; or (b) you received emergency services, but have not been discharged from a facility.

The request for an expedited external review must be made in writing to the Claims Administrator. Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements described above for a standard external review, you will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

External Review by IRO

The Plan will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the adverse benefit determination. You may submit additional information in writing to the IRO within then (10) business days of the IRO's notification that it has been assigned the request for external review.

The IRO will review all information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by you, the Plan, or your treating health care provider;

- the terms of the Plan;
- evidence-based practice guidelines;
- any applicable clinical review criteria developed and used by the Plan; and
- the opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notice of IRO Decision

The IRO will provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan will follow the final external review decision of the IRO (but may initiate judicial review).

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

Legal Action

The claims and review procedures described herein must be utilized and fully exhausted before you may bring a legal action against the University, the Plan Administrator, the Claims Administrator, or the Plan. Unless a Benefit Program provides otherwise, any legal action must be filed within the earlier of (a) three years following the occurrence of the facts or circumstances that gave rise to, or form the basis of, the action, or (b) one year from the date you, your beneficiary, or alternate payee had actual knowledge of the facts or circumstances that gave rise to, or form the basis of, the action.

Cases involving fraud or concealment may not be brought more than three years after the date of discovery of the facts or circumstances that gave rise to, or form the basis of, the action.

Other Important Information

Recovery of Benefits if Payable by a Third Party

Benefits otherwise payable to you (including for your covered Dependents) under the Plan will be reduced to the extent that payment is made directly or indirectly to you or on your behalf, or to your assignee, by any third party or its insurer. This could occur as the result of the actual or alleged wrongful act or omission of any third party (for example, an automobile accident) or a payment made or to be paid from your own no-fault and automobile insurance policy (*i.e.*, uninsured motorist coverage, underinsured motorist coverage, medical payments coverage, no-fault coverage, and/or personal injury coverage).

If the Plan provides benefits to you or your covered Dependent that are later determined to be the legal responsibility of another person, company or insurer, the Plan has a first priority right to recover these payments from you or your covered Dependent in full and regardless of whether you have been made whole.

If you receive or make a claim for benefits before you receive payment from any third party or its insurer, you are considered by the Plan to have agreed that any recovery you receive from any third party or its insurer will be used to repay the Plan for its payments on your behalf. The Plan is entitled to receive full reimbursement before you can keep any amounts recovered from any third party or insurer, without regard to fault, without reduction for attorneys' fees and other costs, and regardless of who receives the payment.

You must inform the Plan Administrator of any action you will take with respect to a third party recovery and may not take any action that will adversely affect the Plan's rights of recovery (including settlement). You agree to cooperate with the Plan as reasonably necessary in any recovery. Failure to comply with the terms of this section may result in a termination of benefits and an obligation to reimburse the Plan for costs and expenses incurred by the Plan in enforcing its rights.

An assignment of your claim to any third party does not exempt you from your responsibility for repayment. To secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim. Any attorney fees or costs incurred by you are not the responsibility of the Plan and are to be paid solely by you. The Plan is entitled to its share of recovery even if you do not recover full damages claimed.

HIPAA Privacy

All Benefit Programs that are group health plans are subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). To receive a copy of the Company's notice regarding the Benefit Programs' compliance with HIPAA privacy rules, or if you have any questions about HIPAA, please contact the Plan Administrator.

Assignment of Benefits

The Benefit Programs summarized in this SPD booklet are used exclusively to provide benefits to you and to your covered eligible Dependents. You cannot assign ownership of or rights to your Plan benefits.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, 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 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 48 hours (or 96 hours).

Uniformed Services Employment and Reemployment Rights Act of 1994

An employee on uniformed services leave is entitled to the same benefits made available to other employees with similar seniority, status and pay, if they were on furlough or leave of absence. If you are an employee and would otherwise lose coverage under this Plan because of a uniformed services leave, you can continue coverage for yourself and your Dependents for the lesser of the length of the leave or 24 months, even if covered by military health care programs. If the uniformed services leave is for less than 31 days, you will pay the same premium contribution as you did while you were an active employee. If the uniformed services leave is for 31 days or more, you may be required to pay 102% of the total premium. If you do not continue coverage during a period of uniformed services leave, your coverage will be reinstated upon reemployment.

ERISA Rights Statement

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

Receive Information About Their Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites and union halls), all Plan documents, 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, upon 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 Plan 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 Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependent children 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health 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 a preexisting 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 upon 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 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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 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, DC 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.

Plan Information

Name of Plan: The University of Chicago Health Care Plans

Name and Address of Plan Sponsor:

The University of Chicago
6054 South Drexel Avenue
Chicago, IL 60637

Employer Identification Number of Plan Sponsor (EIN): 36-2177139

Plan Number: 510

Plan Type: The Plan is an "employee welfare benefit plan" and a "group health plan" for purposes of ERISA. The University of Chicago Medical Program, the University of Chicago Dental Program, the University of Chicago VSP Vision Program, and the University of Chicago Retiree Medical Plan are group health plans.

Plan Year: The financial records of the Plan are kept on a Plan Year basis that ends on each December 31. The Plan Year of each of the Benefit Programs is the 12-month period ending on each December 31.

Plan Administrator: The Plan and Benefit Programs are administered by the University of Chicago, 6054 South Drexel Avenue, Chicago, IL 60637, (773) 702-9634.

The Plan Administrator has the discretionary authority to interpret and apply the Plan's provisions in its sole discretion. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Type of Funding and Administration:

Insured Benefit Programs. The Benefit Programs are provided pursuant to an insurance contract with an insurance company as follows:

Anthem

- *Post-65 Retiree Medical Plan*

BlueCross BlueShield of Illinois

- BCBS HMO Illinois Plan
- BCBS of Illinois PPO for Post-Doctoral Scholars and Fellows
- BCBS of Illinois HMO for Post-Doctoral Scholars and Fellows

Cigna

- CIGNA Global Plan

Metropolitan Life Insurance Company

- MetLife Dental PPO Plan
- MetLife Dental CoPay Plan

Principal Life Insurance Company

- Principal Dental PPO Plan for Post-Doctoral Fellows

Vision Service Plan of Illinois, NFP

- Vision Base Plan
- Vision Premier Plan
- Vision Plan for Post-Doctoral Scholars and Fellows

With respect to these Benefit Programs, the insurance company is responsible for determining the eligibility for benefits and the amount of benefits payable under the Benefit Program and for determining, processing, and paying claims. The insurance company has the discretionary authority to interpret the Plan and to make benefits determinations, to the fullest extent of the law. The Plan Administrator has no authority or responsibility, other than to forward University and employee contributions, if any, to the insurance company. These Benefit Programs are funded by payments of premiums by the University and participants, as determined by the University. A schedule of required contributions is available from the Benefits Office.

Information about the insurance companies listed above, along with their contact information, are contained in the applicable Benefit Program coverage booklet.

Self-Funded Benefit Programs. The following Benefit Programs are administered pursuant to an administrative services contract with the following entities:

BlueCross BlueShield of Illinois

- Maroon Plan
- Maroon Savings Choice
- Pre-65 Retiree Medical Plan

Aetna

- The University of Chicago Health Plan

With respect to these Benefit Programs, the Plan Administrator or its delegate (e.g., the claims administrator) is responsible for determining the eligibility for benefits and the amount of benefits payable under the Benefit Program and for determining, processing, and paying claims. The Claims Administrator also has discretionary authority to interpret the Plan and to make benefits determinations, to the fullest extent of the law. These Benefit Programs are funded by participant and/or employer contributions as determined by the University. A schedule of required contributions is available from the Benefits Office.

Benefits under the self-funded Benefit Program are paid from the general assets of the University and may also be funded by a trust. Benefits under the insured Benefit Programs Assets under the Plan are held pursuant to insurance contracts issued by insurance companies.

Name and Address of Trustee: Benefits under the Retiree Medical Plan are funded in part by The University of Chicago Retiree Medical Trust.

University of Chicago
6054 South Drexel Avenue
Chicago, IL 60637

Claims Administrators: The Claims Administrators of the Benefit Programs, along with their contact information, are contained in the applicable Benefit Program coverage booklet.

Agent for Service of Legal Process: The Plan's agent for service of legal process is the Plan Administrator, at the address noted below:

The University of Chicago
5801 S Ellis Ave, Suite 619
Chicago, IL, 60637

Service of Legal Process may also be made upon the Retiree Medical Plan Trustee at the address noted immediately above.

Plan Termination: The University reserves the right to modify, suspend or terminate the Plan and/or any Benefit Program at any time. The University does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement.

QMCSO: You may obtain a copy of the procedures regarding a Qualified Medical Child Support Order ("QMCSO") from the Plan Administrator at no charge.

Right of Recovery: A Benefit Program has the right to recover benefits it has paid on you or your dependent's behalf that were in excess of the benefit that should have been paid. If a Benefit Program provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Benefit Program may require that the overpayment be returned when requested or reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Benefit Programs

For more information about the benefits under the Plan's Benefit Programs, please reference the following Program documents, which are incorporated herein by reference:

Medical

Maroon Plan

- [BCBS Benefits Booklet](#)

Maroon Savings Choice Plan

- [BCBS Benefits Booklet](#)
- [Preventive Drug List](#)

The University of Chicago Health Plan

- [UCHP Certificate of Coverage](#)

HMO Illinois Plan

- [BCBS Benefits Booklet](#)

BlueCross BlueShield of Illinois PPO for Post-Doctoral Scholars and Fellows

- [BCBS Certificate of Coverage](#)

BlueCross BlueShield of Illinois HMO for Post-Doctoral Scholars and Fellows

- [BCBS Certificate of Coverage](#)

CIGNA Global Plan

- Global Health Advantage Certificate of Coverage (available from the Benefits Office)

Retiree Medical Plan

- [Pre-65 Retiree Medical BCBS Benefits Booklet](#)
- [Post-65 Retiree Medical Anthem Benefits Booklet](#)

Dental

MetLife Dental PPO Plan

- [MetLife Certificate of Coverage](#)

MetLife Dental CoPay Plan

- [MetLife Certificate of Coverage](#)

Principal Dental PPO Plan for Post-Doctoral Fellows

- [Principal Certificate of Insurance – Low Benefit](#)
- [Principal Certificate of Insurance – High Benefit](#)

Vision

Base Plan

- [VSP Evidence of Coverage](#)

Premier Plan

- [VSP Evidence of Coverage](#)

Voluntary PPO Vision Plan for Post-Doctoral Scholars and Fellows

- [Vision Service Plan Certificate of Insurance](#)

Nothing in the Plan or this SPD will be construed to require the University to maintain any fund for its own contributions or segregate any amount that it is obligated to contribute for the benefit of any person, and no person will have any claim against, right to, or security or other interest in, any fund, account or asset of the University from which any payment under the Plan may be made. No benefits under the Plan or any Benefit Program, including the Retiree Medical Plan, are vested. Rights and benefits under the Plan may be amended, modified, changed and terminated by the University at any time for any reason.

The Plan Administrator has the exclusive authority to interpret the terms of the Plan, resolve ambiguities and inconsistencies in the Plan, and make all decisions regarding eligibility and/or entitlement to coverage or benefits and reserves the right to delegate such authority in its discretion.

All decisions of the Plan Administrator or its authorized delegate will be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan or a Benefit Program.