



Guide to Your 2006 Benefits

BENEFITS GUIDEBOOK

THE
UNIVERSITY
OF CHICAGO



Resources

If after reading this Guidebook you need more information about your benefits, you can contact the following resources.

Plan	Additional Resource	Telephone Number	Internet Address
Maroon Plan	BlueCross BlueShield of Illinois	(866) 390-7772	www.bcbsil.com
	Caremark	(866) 873-8632	www.caremark.com
	CareWise	(888) 372-9473	Not available
University of Chicago Health Plan	University of Chicago Health Plan	(773) 834-0900	Not available
Humana Premier HMO	Humana Health Care Plans	(800) 448-6262	www.humana.com
HMO Illinois	HMO Illinois	(800) 892-2803	www.bcbsil.com
First Commonwealth Dental Plan	First Commonwealth	(866) 866-4542	www.firstcommonwealth.net
MetLife Dental Plan	MetLife	(800) 942-0854	www.metlife.com
Long-Term Disability Insurance	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/benefits/spds/ltd/
Group Life Insurance	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/benefits/spds/life_insurance/
Personal Accident Insurance	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/benefits/spds/accident_insurance/
Flexible Spending Accounts	WageWorks	(888) 406-8862	www.wageworks.com
Retirement Plans (SRP, CRP and ERIP)	TIAA-CREF	(800) 842-2776	www.tiaa-cref.org
	Vanguard	(800) 523-1188	www.vanguard.com
	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/forms/pdfs/srp.pdf http://hr.uchicago.edu/benefits/spds/crp/ http://hr.uchicago.edu/benefits/spds/erip/
457(b) Deferred Compensation Plan	TIAA-CREF	(800) 842-2776	www.tiaa-cref.org
	Vanguard	(800) 523-1188	www.vanguard.com
	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/forms/pdfs/plan457.pdf
Long-Term Care Insurance	John Hancock	(773) 363-2257	Not available
	Benefits Office	(773) 702-9634	http://hr.uchicago.edu
Educational Assistance Program	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/benefits/spds/education/
Qualified Transportation Program	WageWorks	(888) 406-8862	www.wageworks.com
Child Care Resource and Referral Service	Benefits Office	(773) 702-9634	http://hr.uchicago.edu/benefits/spds/childref/
	Action for Children	(773) 564-8890	www.daycareaction.org
Staff and Faculty Assistance Program	Perspectives	(800) 456-6327	www.perspectivesltd.com
Elder Care Consultation and Referral Service	Center for Elder Care Choices	(630) 789-8585	www.parentcaresolutions.ws

Table of Contents

page 2

What's in This Guidebook

Overview of Your Benefits	3
Eligible Dependents	5

page 6

Your Open Enrollment Benefits

Changes to Your 2006 Benefits	7
Medical Care	11
Dental Care	18
Long-Term Disability (LTD) Insurance	21
Group Life Insurance	23
Personal Accident Insurance	25
Flexible Spending Accounts (FSAs)	26
Supplemental Retirement Program (SRP)	29
457(b) Deferred Compensation Plan	30

page 31

Monthly Rates for 2006

Medical Care Rates	32
Dental Care Rates	34
LTD Insurance Rates	35
Group Life Insurance Rates	36
Personal Accident Insurance Rates	37

page 38

Additional Benefits

Benefits That Require an Application	39
Benefits That Do Not Require an Application	41

What's in This Guidebook

page 2

This *Guide to Your 2006 Benefits* has been created to explain your University of Chicago employee benefits for 2006 and to provide you with more information about the benefits available to you from the University. It will be a useful tool when you're considering which benefits best fit your needs. If you have any questions after reviewing this Guidebook, please contact the Benefits Office at (773) 702-9634 or benefits@uchicago.edu or visit the University Human Resources Management Web site at <http://hr.uchicago.edu>.

Where to Begin

We don't expect you to read this Guidebook from cover to cover. Depending on your needs and concerns, you may want to turn to the sections that contain the benefits information that is relevant to you.

Contacting the Benefits Office

Here's how you can reach the Benefits Office.

Phone: (773) 702-9634

Fax: (773) 702-0324
Benefits Office

(773) 834-0996
Counseling Office

E-mail: benefits@uchicago.edu

Office hours: 8:30 a.m. – 4:30 p.m.,
weekdays

Mailing address: Benefits Office
The University of Chicago
956 E. 58th Street
Chicago, IL 60637

Walk-in location: Benefits Counseling Office
3rd Floor of the Bookstore
The University of Chicago
970 E. 58th Street
Chicago, IL 60637

Benefits Office versus Benefits Counseling

Office: When you want to visit in person, you should go to the Benefits Counseling Office at 970 E. 58th Street. When you need to mail materials, you should send them to the Benefits Office at 956 E. 58th Street. The phone number and e-mail address are the same for both.

Overview of Your Benefits



BENEFIT ELECTIONS OR CHANGES THAT MUST BE MADE DURING OPEN ENROLLMENT

During Open Enrollment, you are given the opportunity to change or select medical plans, dental plans and Flexible Spending Accounts for health care and/or dependent care expenses for 2006. If you do not make changes to these plans during Open Enrollment, you will have to wait until 2007 to make changes, unless you have a “qualifying change in family status.” (Qualifying changes are described on page 4.) Eligible employees who wish to participate in the 457(b) Deferred Compensation Plan in 2006 must also enroll online during Open Enrollment.

BENEFIT ELECTIONS OR CHANGES THAT CAN BE MADE DURING OPEN ENROLLMENT OR DURING THE YEAR

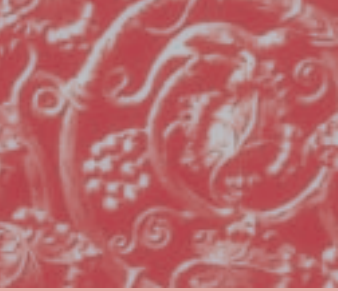
Open Enrollment provides a convenient way to make changes to your current coverage under

the University’s Group Life Insurance plan, Long-Term Disability (LTD) Insurance plan and Personal Accident Insurance plan. It also gives you an easy way to enroll in or make changes to your Supplemental Retirement Program (SRP) account(s).

BENEFITS THAT ARE NOT PART OF OPEN ENROLLMENT

The University provides many other benefits that are not part of Open Enrollment, including the mandatory retirement plans (ERIP and CRP), the Educational Assistance Program, the Qualified Transportation Program (QTP), the Staff and Faculty Assistance Program, referral services for child and elder care and the Travel Accident Insurance Program. Please see the chart below for a list of these benefits offered through the Benefits Office. For more details, visit <http://hr.uchicago.edu>.

Benefit Elections or Changes That Must Be Made During Open Enrollment	Benefit Elections or Changes That Can Be Made During Open Enrollment or During the Year	Benefits That Are NOT Part of Open Enrollment
<ul style="list-style-type: none"> ■ Medical Care ■ Dental Care ■ Health Care Flexible Spending Account ■ Dependent Care Flexible Spending Account ■ 457(b) Deferred Compensation Plan 	<ul style="list-style-type: none"> ■ Group Life Insurance ■ Long-Term Disability (LTD) Insurance ■ Personal Accident Insurance ■ Supplemental Retirement Program (SRP) 	<ul style="list-style-type: none"> ■ Retirement Income Plan for Employees (ERIP) ■ Contributory Retirement Plan (CRP) ■ Long-Term Care Insurance ■ Educational Assistance Program ■ Qualified Transportation Program (QTP) ■ Travel Accident Insurance Program ■ Staff and Faculty Assistance Program ■ Child Care Referral Programs ■ Elder Care Consultation and Referral Service



Qualifying Change in Family Status

A “qualifying change in family status” is a life event that affects the level of benefits coverage you need. Qualifying changes include:

- Marriage
- Divorce
- Birth of a baby
- Adoption of a child
- Loss or change of your spouse’s/domestic partner’s coverage through his or her employer
- Registration of a domestic partner with the University
- Termination of a domestic partnership, or
- Death.

If one of these events occurs, you’re allowed to change your current coverage within 31 days to reflect the event. If you do not make a change within 31 days of the qualifying event, you will need to wait until the next annual Open Enrollment to make the change.

The change you want to make to your coverage — adding or dropping yourself or your dependents — must be consistent with your status change. For example, if you and your spouse have a child during the year, you can add your child to your current medical plan within 31 days. However, you and your spouse cannot switch to a different medical plan until the next Open Enrollment period.

Eligible Dependents

WHO CAN BE COVERED

As you read the descriptions of your benefits in the upcoming pages, you will see that you can cover your dependents under many of your benefits. Your dependents include:

- Your spouse
- Your University-approved domestic partner
- Your children up to age 23.

DOMESTIC PARTNERS

You may enroll your same-gender domestic partner as a dependent for your 2006 benefits only if he or she is registered with the Benefits Office. If you do not have a University-approved Statement of Domestic Partnership and you wish to add your partner, you can register him or her during Open Enrollment by completing a Statement of Domestic Partnership form online or by visiting the Benefits Counseling Office between 8:30 a.m. and 4:30 p.m. weekdays. Your domestic partner's benefits will be effective from the date the Statement of Domestic Partnership form is approved.

The University defines domestic partners as 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 Open Enrollment Benefits

page 6

There are some changes to your benefits for 2006. For information on the changes that take effect on January 1, 2006, refer to “Changes to Your 2006 Benefits.” For a more detailed look at the benefits that you may choose during Open Enrollment, refer to the descriptions beginning on page 11.

Changes to Your 2006 Benefits



MEDICAL PLAN CHANGES

The following are some of the key changes to your medical benefits for 2006. For more information on your medical care options, read page 11.

Salary Tiers

Your salary tier, your full-time or part-time status and your coverage level (yourself only, yourself and one dependent, or yourself and your family) determine your monthly medical contribution rates. For all medical plans in 2006, the first salary tier will increase by \$1,000 — from \$35,999 to \$36,999. This means the second salary tier will be \$37,000 – \$59,999. The other two salary tiers will remain the same as in 2005.

Maroon Plan Enhancements

■ **Increased wellness benefit.** Effective January 1, 2006, the annual wellness benefit will increase from \$100 to \$300 per covered participant, meaning you and your covered dependents will have greater coverage for routine medical expenses, such as preventive screenings and immunizations. Please note that routine medical expenses incurred over \$300 per person annually will not be covered by the Plan. (Please refer to the Summary Plan Description for the Maroon Plan at <http://hr.uchicago.edu/benefits/spds/medical/> for more detailed information about this wellness benefit.)

■ **Access to CareWise Nurse Advice Line.**

Effective immediately, you will have access to this voluntary, free service that offers round-the-clock information and support on health-related issues. For example, if you can't reach your doctor and are wondering whether you should go to an emergency room in the middle of the night, the Nurse Advice Line can help you determine whether you need immediate medical attention. Simply call (888) 372-9473 to talk with a health care professional who can help answer any health-related questions you may have. As a reminder, this number is only for employees and their dependents covered under the Maroon Plan. Please refer to the chart on pages 16 – 17 to find information on the Nurse Advice Line for other health plans.



2006 EMPLOYEE RATES

For 2006, employee contribution rates for all medical plans, the First Commonwealth Dental Plan and Long-Term Disability (LTD) Insurance will increase. Contribution rates for Group Life Insurance, Personal Accident Insurance and the MetLife Dental Plan will remain unchanged for 2006. For more information on 2006 employee contribution rates, turn to page 31.

CHANGES TO YOUR FLEXIBLE SPENDING ACCOUNTS (FSAs)

Relief From the “Use It or Lose It” Rule

Recently, the IRS extended the deadline for incurring claims in a Health Care FSA and a Dependent Care FSA. The regulations allow employees to use money remaining in the FSA on December 31 of each year for qualified expenses in the first two and one-half months of the next year. This means you can use your 2005 account balance until March 15, 2006. For example, let's say you have \$200 left in your Health Care FSA at the end of 2005 and, at your annual vision examination on February 10, 2006, you learn you need prescription glasses. You can use the \$200 left in your Health Care FSA at the end of 2005 to help pay for this expense in February 2006. You should also note that you now have until June 30, 2006 to submit claims for 2005. In summary, you have until March 15, 2006, to use your 2005 contributions and then until June 30, 2006 to submit claims incurred between January 1, 2005 and March 15, 2006.

The Dependent Care FSA Limit

For the Dependent Care FSA, the annual maximum amount that highly compensated employees may contribute has been reduced to \$1,900 for 2006 in order to pass government test rules. In 2005 the IRS defined highly compensated employees as those who earned an annual salary of \$95,000 or more. For 2006, the IRS deemed those who earn \$100,000 or more annually to be highly compensated. All other employees may contribute up to \$5,000 in 2006. For more information, turn to page 26.



SUPPLEMENTAL RETIREMENT PROGRAM (SRP)

For calendar year 2006, the maximum amount that you may contribute to the SRP will increase as follows:

- All benefits-eligible employees may contribute \$15,000 — an increase from \$14,000 in 2005.
- All benefits-eligible employees age 50 or older (including those who will attain age 50 by December 31, 2006) may contribute an additional \$5,000. In other words, all benefits-eligible employees age 50 or older may contribute \$20,000 — an increase from \$18,000 in 2005.

You do not need to do anything during Open Enrollment if you wish to keep the same SRP contribution and investment allocations that are in effect on October 21, 2005. However, if you are currently contributing the 2005 maximum and wish to contribute the increased 2006 maximum, you will need to elect the new increased maximum on the Internet during Open Enrollment.

For more details, please refer to *"The Supplemental Retirement Program: Enrollment Guide 2006,"* which can be found online at <http://hr.uchicago.edu> beginning in late October.

Save More Tomorrow™ (SMarT)

If you are contributing to the SRP but are not contributing the maximum amount allowed by law, you may want to take advantage of the Save More Tomorrow™ (SMarT) enhancement to the SRP. By enrolling in SMarT during Open Enrollment, you may choose to allocate a portion of your future pay increases as retirement savings. In this way, you make progress toward your retirement goals by scheduling automatic annual increases in your SRP contribution rate. If you elect the SMarT program, you will not be required to complete a new salary reduction agreement each time you wish to increase your contribution. Instead, your contribution will automatically increase by the dollar amount you specify (up to the annual maximum) in the month you specify when you elect SMarT. To participate in SMarT, you must enroll on the Internet during Open Enrollment.

Here is an example of how SMarT works. You may want to increase your SRP contributions by \$50 automatically each year when you receive your annual salary increase. Assuming your salary increase goes into effect on July 1 of each calendar year, during Open Enrollment you would elect a \$50 increase to go into effect on July 1, 2006, and each July 1 thereafter.

Note: If you do not enroll in SMarT, you can still increase, decrease or suspend your contributions as in the past. SMarT is simply a convenient way to help you increase your retirement plan contributions without having to take any further action each year.



457(B) DEFERRED COMPENSATION PLAN

The 457(b) Deferred Compensation Plan is a nonqualified plan of deferred compensation available to a relatively small group of faculty and staff who satisfy the plan's eligibility requirements.

You are eligible to participate in this plan effective January 1, 2006 if:

- Your "benefit base salary" as of the monthly payroll closing day for October 2005 equals or exceeds 175% of the 2005 Social Security taxable wage base. In other words, your benefit base salary as of October 21, 2005 must equal or exceed **\$157,500**. Your "benefit base salary" does not include clinical bonuses, extra service pay and compensation for service performed while you are out of residence; and
- You enroll in the 2006 Supplemental Retirement Program (SRP) for your maximum permissible contribution coincident with or prior to submitting your Section 457(b) plan enrollment.

Participation in this plan is voluntary. For 2006, eligible faculty and staff may elect to defer receipt of part of their compensation (up to **\$15,000**) until their University employment has ended. Amounts deferred under the plan will not be included in taxable income until you leave the University. The University does not contribute to the Section 457(b) plan.

If you are eligible and wish to participate effective January 1, 2006, **you must enroll on the Internet as part of the University's annual Open Enrollment for benefits beginning Monday, November 7, 2005 and ending Tuesday, November 15, 2005**. It is necessary for you to renew your Section 457(b) plan enrollment for 2006 even if you participated in the plan in 2005.

The Section 457(b) plan offers only two entry dates: January 1 and July 1. If you do not complete your enrollment on the Internet during the annual Open Enrollment period, your eligibility will be re-determined as of the monthly payroll closing day for April 2006 and, if you are eligible to participate, you will be provided the opportunity to enroll effective July 1, 2006.

Faculty and staff who are eligible to participate in this plan can find more details in the booklet entitled "*457(b) Deferred Compensation Plan: Enrollment Guide 2006*," which is available through the UHRM Web site at <http://hr.uchicago.edu>. Please read the information provided and consult your professional tax or financial advisor before deciding whether Section 457(b) plan participation is appropriate for you.



OPTIONS

The University offers you two types of medical coverage:

- A preferred provider organization (PPO), or
- A health maintenance organization (HMO).

You may also elect to waive medical coverage.

The University offers two HMOs — the Humana Premier HMO and HMO Illinois — and an option that works like an HMO, the University of Chicago Health Plan (UCHP). All three options operate in the Chicago area.

If you decline medical coverage, you will not be able to elect it until the next Open Enrollment period, unless you have a qualifying change in family status. (See page 4 for an explanation of qualifying changes in family status.)

HOW THE OPTIONS WORK

Maroon Plan

If you are a Maroon Plan participant, you are free to receive care from any licensed doctor and hospital that you choose. Your costs and claim procedures vary, however, depending on which provider you decide to visit.

When you visit a provider that belongs to the BlueCross BlueShield of Illinois (BCBSIL) preferred provider network, the Maroon Plan pays 80% of the cost of your covered services after you meet the annual deductible, and you pay the remaining amount. If you enroll in the Maroon Plan for 2006 and select coverage for yourself only, you will need to meet a \$250 deductible before the Plan will begin to pay benefits for covered

expenses. If you select coverage for yourself and one dependent, each covered individual will need to meet a \$250 deductible (a total of a \$500 deductible for both individuals) before the Plan will begin to pay any benefits for covered expenses. If you select coverage for yourself and your family, each covered individual will need to meet a \$250 deductible (until a maximum \$600 deductible for the family) before the Plan will begin to pay any benefits for covered expenses. The BCBSIL provider files your claim for you.

Important Maroon Plan Changes for 2006

The following are some of the key changes to the Maroon Plan effective January 1, 2006:

- The annual wellness benefit will increase from \$100 to \$300 per covered participant, meaning you and your covered dependents will have greater coverage for routine medical expenses, such as preventive screenings and immunizations.
- Effective immediately, you will have access to the CareWise Nurse Advice Line, a voluntary, free service that offers round-the-clock information and support on health-related issues. Simply call (888) 372-9473 to talk with a health care professional who can help answer any health-related questions you may have.



When you visit a provider that does not belong to the BCBSIL preferred provider network, the Maroon Plan pays 65% of the cost of covered services based on the prevailing fee schedule after you meet the annual deductible, and you pay the remainder. If you enroll in the Maroon Plan for 2006 and select coverage for yourself only, you will need to meet a \$250 deductible before the Plan will begin to pay benefits for covered expenses. If you select coverage for yourself and one dependent, each covered individual will need to meet a \$250 deductible (a total of a \$500 deductible for both individuals) before the Plan will begin to pay any benefits for covered expenses.

If You Receive Care Out-of-Network

BCBSIL negotiates significant discounts with providers who are part of its network. As a result, when you use a provider that does not belong to the BCBSIL network, the prevailing fee schedule can be significantly lower as compared with what your provider charges for some services.

You should check with BCBSIL before receiving care from a provider who is not part of the Plan's network, because the Plan will only reimburse you for 65% of the expenses (after you meet the annual deductible) based on the prevailing fee schedule. You are responsible for any amount that is more than 65% of what is listed in the prevailing fee schedule for the health care services. Keep in mind that any amount you pay over the prevailing fee schedule will not count toward your out-of-pocket maximum.

If you select coverage for yourself and your family, each covered individual will need to meet a \$250 deductible (until a maximum \$600 deductible for the family) before the Plan will begin to pay any benefits for covered expenses.

In addition, if you are admitted to a hospital that does not belong to the BCBSIL network, you must meet an additional \$200 deductible before the Plan covers any of your expenses. You are responsible for filing your own claim forms.

With providers that do not belong to the BCBSIL preferred provider network, the Maroon Plan pays for expenses based on the "prevailing fee schedule" (as determined by BCBSIL). Because BCBSIL negotiates significant discounts with providers who are part of its network, the prevailing fee schedule can be significantly lower as compared with what your provider charges for some services.

The Maroon Plan has an out-of-pocket maximum — the maximum amount you have to pay each year toward medical care costs. Once you reach the out-of-pocket maximum, the Maroon Plan pays 100% of the cost of your covered services. Your annual salary determines your out-of-pocket maximum.

Please Note: The wellness benefit has increased to \$300 per person per calendar year. Routine medical expenses, such as routine exams and immunizations, incurred over \$300 per person annually will not be covered by the Plan.



HEALTH MAINTENANCE ORGANIZATIONS

The University offers two HMOs — the Humana Premier HMO and HMO Illinois — and an option that works like an HMO, the University of Chicago Health Plan (UCHP). All three options operate in the Chicago area.

An HMO is a managed care network. To receive coverage, you must see the doctors and hospitals associated with your HMO, except when you need emergency care. The HMO options do not have deductibles. When you receive care, the HMO generally pays 100% of the cost after you pay a minimal copayment.

Things to Consider

If you are considering enrolling in an HMO, remember that to receive coverage, you and your enrolled dependents must use providers who are part of your HMO's network, except in an emergency. The University offers HMOs with networks in the Chicago area. If you have dependents who are planning to attend college outside your HMO's network area, keep in mind that any care they receive out of the network area may not be covered by your HMO.

Did You Know?

- Each medical plan has a three-tier prescription drug program. When you use generic drugs or drugs listed on your medical plan's preferred brand-name list (also known as a formulary), you will purchase prescription drugs in the most cost-effective way. See pages 16 – 17 for exact copayments.
- The plans also offer a mail service feature for when you need ongoing medication. This feature is a convenient and cost-effective way to purchase prescription drugs. Under this option you can receive up to a 90-day supply of your prescription drugs. Turn to pages 16 – 17 to see the cost savings available through the mail service feature.

Under an HMO, you choose a primary care physician (PCP) who helps you manage your medical care within the HMO network. Your primary care physician must authorize all medical care you receive. For example, your PCP must refer you if you want to see a specialist, or the HMO will not cover the cost.



PRESCRIPTION DRUG PROGRAM UNDER ALL HEALTH PLANS

Prescription drug copayments under all four health plans are based on a three-tier prescription drug program. The three-tier prescription drug program gives you access to three types of drugs: generic, preferred brand-name and non-preferred brand-name.

The prescription drug program has a retail and a mail service feature. Under the retail feature of this program, you can visit any network pharmacy for your short-term prescription drug needs. You can receive up to a 30-day supply of your prescription drugs after you pay the applicable copayment (see pages 16 – 17).

If you have a condition that requires ongoing medication, you may prefer to use the mail service feature. This feature is a convenient and cost-effective way to purchase maintenance drugs. Maintenance drugs are prescription drugs taken over a period of time for a chronic or ongoing condition, such as arthritis, diabetes, high blood pressure or asthma.

Under the mail service feature, you can receive up to a 90-day supply of your prescription drugs after you pay the applicable copayment.

Generic Drugs, Preferred Brand-Name and Non-Preferred Brand-Name Drugs

- **Generic Drugs** — Generic drugs are sold under the drug’s chemical, generic name. Generic drugs must contain the same active chemical ingredients and be equivalent in strength and dosage form to the brand-name product. The federal Food and Drug Administration (FDA) regulates the quality, strength and purity of generic drugs. Generic drugs are typically the most cost-effective.
- **Preferred Brand-Name Drugs** — Brand-name drugs are drugs that are advertised and sold under a product name chosen by the manufacturer. Those that are on the preferred brand-name list (also known as a formulary) have been approved for use and coverage by the medical plan. Using drugs on the preferred brand-name list is more cost-effective than using brand-name drugs that are not on the list.
- **Non-Preferred Brand-Name Drugs** — Brand-name drugs are drugs that are advertised and sold under a product name chosen by the manufacturer. Those that are not on the preferred brand-name list offered by your medical plan are the least cost-effective.

For a listing of preferred brand-name drugs contact your health plan.



By using the mail service feature, you save money because under the retail service feature, not only are you restricted to a maximum 30-day supply at a time for any prescription drug, but you also pay higher copayments.

The program also offers you the option of combining the retail and mail service features when you need ongoing prescription drugs. For example, if you need ongoing medication, you can ask your medical care provider to provide two prescriptions — one for a 30-day supply of your medication and another ongoing prescription. You can purchase up to a 30-day supply for your immediate needs at any network pharmacy and order up to a 90-day supply for your ongoing needs through the program's mail service feature.

MEDICAL PLAN COMPARISON CHART

When you're deciding which medical option to choose, there are a number of points to consider. Do you want a plan that offers you more access to providers? Are you looking for a plan with lower costs? Do you want to have one doctor to coordinate all your care? What kind of coverage do you want?

Each of your medical options has unique features. Review the chart on the following pages to understand the differences among the medical options.

Plan Feature	Maroon Plan		
	Inside BCBSIL Network	Outside BCBSIL Network	
Choice of doctor	Limited to BCBSIL network	Any provider	
Deductible	Individual — \$250 Individual plus one — up to \$500 Family — up to \$600	Individual — \$250 Individual plus one — up to \$500 Family — up to \$600 Additional \$200 per hospital admission	
Prevailing fee schedule	None	Yes	
Benefit payment percentage	You pay 20%; Plan pays 80% of covered expenses	You pay 35%*; Plan pays 65% of the costs based on the prevailing fee schedule	
Out-of-pocket maximum	Out-of-pocket maximum based on salary:		
	Salary	Individual	Family
	Under \$37,000	\$1,000	\$2,000
	\$37,000 – \$59,999	\$2,000	\$4,000
	\$60,000 – \$89,999	\$3,000	\$6,000
	\$90,000 and above	\$4,000	\$8,000
Claim forms	None	You file your claim	
Physician office visits	You pay 20%; Plan pays 80%	You pay 35%*; Plan pays 65% of the costs based on the prevailing fee schedule	
Hospital: Inpatient	You pay 20%; Plan pays 80%	You pay 35% (after \$200 deductible)*; Plan pays 65% of the costs based on the prevailing fee schedule	
Hospital: Outpatient	You pay 20%; Plan pays 80%	You pay 35%*; Plan pays 65% of the costs based on the prevailing fee schedule	
Wellness benefits	\$300 annual wellness benefit per person		
Ongoing therapy, occupational therapy, physical therapy and speech therapy	Reviewed after a total of 20 sessions to determine medical necessity regardless of when services are incurred		
Hearing services	Not covered		
Vision services	Discounts for care and supplies received from an EyeMed Vision Care network provider; contact (866) 273-0813		
Prescriptions (Generic/Preferred Brand-Name/Non-Preferred Brand-Name)	Covered under a separate prescription drug plan administered by Caremark Retail (30-day supply): \$8/\$20/\$35 copayment Mail Service (90-day supply): \$16/\$40/\$70 copayment		
Lifetime maximum	\$2,000,000		
Emergency room	You pay 20%; Plan pays 80% of covered expenses	You pay 35%*; Plan pays 65% of the costs based on the prevailing fee schedule	
Mental health: Outpatient	You pay 20%; Plan pays 80%; maximum of 30 visits per calendar year	You pay 35%*; Plan pays 65% of the costs based on the prevailing fee schedule; maximum of 30 visits per calendar year	
Nurse Advice Line	Contact CareWise at (888) 372-9473		

*You are also responsible for any amount above the prevailing fee schedule.



University of Chicago Health Plan	Humana Premier HMO	HMO Illinois
Limited to network	Limited to network	Limited to network
None	None	None
None	None	None
You pay nothing or minimal copayment; Plan pays 100%	You pay nothing or minimal copayment; Plan pays 100%	You pay nothing or minimal copayment; Plan pays 100%
None	None	None
None	None	None
You pay \$10 copayment; Plan covers the remainder	You pay \$10 copayment for a primary Care Physician visit and \$20 for a specialist visit; Plan covers the remainder	You pay \$10 copayment; Plan covers the remainder
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
Provided in full	Provided in full	Provided in full
Some preventive care covered	Some preventive care covered	Some preventive care covered
Limit of 60 combined treatments per calendar year	PCP and any consulting physician must determine that the member's condition can improve significantly within 2 months	Limit of 60 combined treatments per calendar year
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
Contact the Plan at (773) 834-0900	Contact EyeMed Vision Care at (888) 289-0595	Contact EyeMed Vision Care at (866) 273-0817
Retail (30-day supply): \$5/\$15/\$30 copayment Mail Service (90-day supply): \$10/\$30/\$60 copayment	Retail (30-day supply): \$5/\$15/\$30 copayment Mail Service (90-day supply): \$10/\$30/\$60 copayment	Retail (30-day supply): \$5/\$15/\$30 copayment Mail Service (90-day supply): \$10/\$30/\$60 copayment
None	None	None
\$50 copayment	None	\$50 copayment
\$20 copayment per visit (waived for initial visit); limited to 20 visits per person per calendar year	\$20 copayment per visit; limited to 20 visits per person per calendar year	\$20 copayment per visit (waived for initial visit); limited to 20 visits per person per calendar year
Contact your PCP	Contact Humana First at (800) 622-9529	Contact your PCP

Dental Care

The University of Chicago's dental options provide coverage for different types of dental care — from preventive care to orthodontia.

OPTIONS

The University offers two options for dental coverage:

- The First Commonwealth Dental Plan (a Dental Health Maintenance Organization)
- The MetLife Dental Plan (a Dental Preferred Provider Organization).

You also have the option to waive dental coverage.

Once you choose a dental option, you cannot drop coverage or change your election until the next Open Enrollment, unless you have a qualifying change in family status. **Please Note:** You can add dependents to your dental coverage if you experience a qualifying change in status during the year. However, you can drop dependents from your dental coverage only in the event of a death, divorce or child reaching age 23. (See page 4 for an explanation of qualifying changes in family status.)

HOW THE OPTIONS WORK

The First Commonwealth Dental Plan (a Dental Health Maintenance Organization)

The First Commonwealth Dental Plan is a dental health maintenance organization (dental HMO). When you enroll in the Plan, you select a general dentist from the list of providers who participate in the First Commonwealth network. If you need dental treatment or services, you must go to your general dentist in order to receive Plan benefits. Your general dentist will refer you to a network specialist, if necessary.

Routine checkups are provided to you at no cost. For other covered services, you pay a fixed percentage of a set fee agreed upon by the providers under their contract with First Commonwealth — 0% for preventive care, 20% for basic services and 50% for major services. You pay this coinsurance to your dentist at the time of the service but you do not have to meet a deductible. The Plan limits coverage for orthodontia to a lifetime maximum of \$1,000. There are no other maximums and you do not have to submit any claim forms.

The MetLife Dental Plan (a Dental Preferred Provider Organization)

The MetLife Dental Plan is a dental preferred provider organization (dental PPO). When you enroll in the Plan, you are free to visit any licensed dentist you choose. You and your dependents must meet an annual deductible of \$60 per person for most types of care (waived for preventive care and orthodontia). Once you meet this annual deductible, the Plan pays a percentage of your costs, usually 80% for covered basic services and 50% for covered major services. You pay the difference. Preventive services are the exception — the Plan will pay 100% of your charges, including up to two cleanings or oral exams a year, separated by six months.



The Plan pays a percentage of your costs up to an annual maximum of \$1,500 per person or \$3,000 per family. In the case of orthodontia, the Plan pays a lifetime maximum of \$1,000 per person.

Your costs and claim procedures vary, however, depending on whether you visit a “preferred provider” (i.e., a provider who is a part of the Plan’s network).

If you visit a preferred provider, you enjoy certain advantages, such as:

- **Negotiated fees** — You save money because preferred providers agree to charge Plan participants fees negotiated by MetLife.
- **No claim forms** — Your dentist will file your claims for you.
- **Access to providers that meet MetLife’s quality standards** — All preferred providers undergo MetLife’s strict screening process including a review of the provider’s background, license and infection control compliance to ensure they meet high quality standards.

If you visit a licensed dentist who is not a part of the MetLife network:

- You and your dependents are responsible for filing your own claims.
- The Plan will pay for expenses based on “reasonable and customary” fees, as determined by MetLife. You are responsible for paying any costs above these fees. Keep in mind that costs associated with dental services can vary depending on the method and materials used by your dentist. However, your MetLife dental benefit will be based on the lowest-cost method or material which meets generally accepted dental standards. The Plan will not be responsible for covering any additional costs.

If your current dentist is not a part of MetLife’s network and is interested in joining the network, you can nominate him or her by completing the PDP Dentist Nomination Card. Please contact MetLife at (800) 942-0854 or www.metlife.com for additional information. Dentists who are interested in joining MetLife’s network must pass a screening process before they are accepted into the network.



DENTAL PLAN COMPARISON CHART

There is a difference in the level of benefit coverage between First Commonwealth and MetLife. The MetLife Dental Plan can offer you greater freedom to visit a dentist of your choice, but the First Commonwealth Dental Plan has lower monthly premiums and costs for care. For a closer look at the differences between the plans, refer to the chart.

	First Commonwealth Dental Plan	MetLife Dental Plan	
		In-Network	Out-of-Network
Choice of dentist	Limited to network providers	Limited to network providers	Any dentist
Deductible	None	\$60 per person (waived for preventive care and orthodontia)	
Preventive care	Plan pays 100% — up to 2 visits per calendar year separated by 6 months	Plan pays 100% — up to 2 visits per calendar year (no deductible, no coinsurance) separated by 6 months	Plan pays 100% of the reasonable and customary charges — up to 2 visits per calendar year (no deductible, no coinsurance) separated by 6 months
Basic care	You make copayment (approximately 20% of the cost), then Plan pays the remainder	You pay 20%; Plan pays 80% (up to annual maximum)*	You pay 20%; Plan pays 80% (up to annual maximum)*; you pay any amount over the reasonable and customary charges
Major care	You make copayment (approximately 50% of the cost), then Plan pays the remainder	You pay 50%; Plan pays 50% (up to annual maximum)*	You pay 50%; Plan pays 50% (up to annual maximum)*; you pay any amount over the reasonable and customary charges
Orthodontia	You make copayment (approximately 50% of the cost), then Plan pays the remainder (up to lifetime orthodontia maximum of \$1,000)	You pay 50%; Plan pays 50% (up to lifetime orthodontia maximum of \$1,000)	You pay 50%; Plan pays 50% (up to lifetime orthodontia maximum of \$1,000); you pay any amount over the reasonable and customary charges
Annual maximum benefit*			
■ Covered individual	■ None		■ \$1,500
■ Family	■ None		■ \$3,000
Claim forms	No	No	Yes
Negotiated fees	Yes	Yes	No

* The annual maximum benefit is the most coverage that the Plan will provide you in one calendar year. You are responsible for all dental costs after you reach your annual maximum benefit.

Long-Term Disability (LTD) Insurance



The Long-Term Disability (LTD) Plan is designed to help compensate you for loss of income due to a serious accident or illness.

OPTIONS

There are two Long-Term Disability Plan options:

- Base Plan
- Optional Plan.

Coverage for Various Employees

For Non-Highly Compensated Staff Employees

If you enrolled in the Base or Optional LTD Plan within your first 31 days of employment, your coverage will take effect after 90 days on the job. Coverage is mandatory for Local 743 employees and confidential employees after 90 days.

Note that you are automatically enrolled in the Base LTD Plan on the date your participation in ERIP, the staff retirement plan, begins. For employees hired on or after July 1, 2005, participation in ERIP is mandatory if you are age 21 or older and have completed a year of service with the University.

For Academic Employees and Highly Compensated Staff Employees

You are required to have Base Plan coverage if you are a participant in the Contributory Retirement Plan, which starts on your date of

hire. During your first 31 days you may elect coverage under the Optional Plan with no proof of insurability.

Applying for Optional Coverage After Your First 31 Days of Employment

If you are in the Base LTD Plan and wish to apply for coverage under the Optional LTD Plan, you may apply at anytime through the Benefits Counseling Office. Coverage is not automatic. You must complete a Statement of Health and the insurance company has sole authority to approve or deny your application based on proof of insurability.

Employees Age 65 or Older

Employees who are age 65 or older may waive LTD coverage. However, if you waive coverage, you may not subsequently reenroll.



HOW THE OPTIONS WORK

If you are disabled and you cannot work, the Long-Term Disability Plan provides you with a portion of your salary.

If you are disabled and you are in the Base Plan, you will receive 60% of your monthly base salary, minus the sum of benefits you receive from other sources. You can receive up to a maximum of \$10,000 per month. Benefits start on the first day of the month after you have been continuously disabled for three months.

Please Note: For information on short-term disability, contact the Office of Wage and Salary Administration.

The Optional Plan provides enhanced benefits above and beyond those offered by the Base Plan. First, it features a built-in cost of living adjustment that will increase your benefit by 5% each year while you are disabled. Second, the Optional Plan employs a more liberal definition of disability. To be eligible for benefits under the Base Plan, you must be unable to perform any occupation; the Optional Plan employs an “own occupation” definition of disability. In other words, it pays benefits as long as your disability precludes you from being able to perform your own occupation (regardless of whether or not you could do some other job). And finally, the monthly maximum benefit under the Optional Plan is \$20,000.

If you become disabled under either the Base Plan or the Optional Plan, you may continue your medical, dental, life and personal accident insurance at the same employee premiums you would pay as an active employee. The University will make both the employee and University contributions to your ERIP or CRP retirement plan.

If you increase your coverage from the Base Plan to the Optional Plan, you must prove your insurability by completing a Statement of Health form. A Statement of Health form asks you to complete a series of health-related questions; your answers determine your eligibility for the increase in coverage. **Your coverage will not go into effect in 2006 until the carrier approves your increase in coverage.** The approval process usually takes six weeks to complete. If the carrier does not approve your increased coverage, you will continue to receive your current 2005 coverage.

If You Are a Newly Hired Employee

If you enroll in the LTD Optional Plan within 31 days of your date of hire, you do not have to complete a Statement of Health form.

Group Life Insurance



Group Life Insurance will pay your beneficiary as much as four times your salary in the event of your death.

OPTIONS

The University of Chicago provides basic life insurance coverage to you at no cost. You have the option to elect additional life insurance for a combined life insurance benefit coverage equal to one, two, three or four times your annual benefits-eligible salary.

HOW THE OPTIONS WORK

Basic life insurance provides full-time employees with \$12,000 of coverage and part-time employees with \$6,000 of coverage.

If you are under 65 years of age, you may choose to purchase life insurance in multiples of one, two, three or four times your annual benefits-eligible salary (rounded up to the nearest thousand). The maximum is \$1,000,000, and proof of insurability with a Statement of Health is needed if you elect an amount over \$600,000. For example, an employee whose salary is \$25,000 may elect coverage up to \$100,000 (4 x \$25,000). An employee whose salary is \$300,000, however, could elect \$1 million in coverage only with proof of insurability.

Any time you increase your coverage amount or elect an amount that exceeds \$600,000, you must prove your insurability by completing a Statement of Health form. A Statement of Health form asks you to complete a series of health-related questions; your answers determine your eligibility for the increase in coverage. **Your coverage will not go into effect in 2006 until the carrier approves your increase in coverage.** You will be notified in writing of the carrier's decision.

The decision process usually takes six weeks to complete. If the carrier does not approve your increased coverage, you will continue to receive your current 2005 coverage.

When your employment ends with the University, you may apply to the insurance company to continue your life insurance coverage under the portability or conversion provisions of the insurance contract.



If You Are a Newly Hired Employee

If you enroll in Group Life Insurance within 31 days of your date of hire, you do not have to complete a Statement of Health form for coverage up to \$600,000.

When you reach age 65, your elected coverage is reduced to the following reduction factor:

Age 65 – 69: 65%

Age 70 – 74: 42%

Age 75 and over: 27%

If you wish to increase your coverage, or increase your maximum level to \$650,000, you must prove insurability by completing a Statement of Health form. The maximum available amount of life insurance coverage at age 65 – 69 is \$650,000; at age 70 – 74 is \$420,000; and at age 75 and over is \$270,000.

Choosing Your Beneficiary

Life insurance participants must designate a beneficiary. If you are electing life insurance for the first time, please contact the Benefits Office to make your designation. If you would like to change your designation, visit the Benefits Counseling Office to fill out a Notice of Change in Beneficiary form.

Personal Accident Insurance



Personal Accident Insurance provides insurance protection from the financial hardship your family may suffer if you lose your life or are seriously injured in an accident. Coverage depends on the circumstances of your accident.

OPTION

You may elect individual or family coverage. For enrollment purposes, these coverage levels are referred to as “Yourself Only” and “Yourself and Your Family.”

HOW THE OPTION WORKS

If you are involved in an accident that results in dismemberment or death (within one year of the accident), you or your beneficiary will receive a benefit.

The amount of your benefit depends on the nature of your loss and your elected coverage. You may purchase from \$20,000 to \$500,000 of insurance. Coverage must be purchased in multiples of \$10,000. After you reach age 70, coverage will be reduced. (This reduction also applies to your covered spouse, if you have family coverage.)

The reduction factors are as follows:

Age 70 – 74: 65%

Age 75 – 79: 45%

Age 80 – 84: 30%

Age 85 and over: 15%

The reduction takes place at the end of the calendar year in which the stated age is attained. Note: You cannot increase your elected coverage once you reach age 70.

If you choose family coverage, your spouse and children may also be covered under Personal Accident Insurance, in addition to yourself. You are the beneficiary for your spouse and children.

- If your spouse is injured or dies, the Plan will pay a benefit equal to 50% of your coverage.
- If your child is injured or dies, the Plan will pay a benefit equal to 15% of your coverage.
- If both you and your spouse die as a result of the same accident within 90 days of the accident, your spouse’s coverage is equal to your coverage.

Choosing Your Beneficiary

If you elect Personal Accident Insurance, you need to designate a beneficiary. If you are electing Personal Accident Insurance for the first time, contact the Benefits Office to make your designation. If you would like to change your designation, visit the Benefits Counseling Office to fill out an Information for Personal Accident Insurance form.

Flexible Spending Accounts (FSAs)

page 26

Health Care FSAs and Dependent Care FSAs are accounts in which you set aside pre-tax money to pay for health care or dependent care expenses. Because your FSA contributions are deducted from your paycheck before taxes are calculated, FSAs can help you save money by reducing your taxable income.

Annual FSA Enrollment Required

You must enroll in the Flexible Spending Accounts each year. If you do not reenroll during the annual Open Enrollment period, you must wait until the next annual Open Enrollment, unless you have a qualifying change in family status.

OPTIONS

You may elect to participate in a:

- Health Care Flexible Spending Account, and/or
- Dependent Care Flexible Spending Account.

Important Plan Change for 2006

Recently, the IRS extended the deadline for incurring claims in a Health Care FSA and a Dependent Care FSA. The regulations allow employees to use money remaining in the FSA on December 31 of each year for qualified expenses in the first two and one-half months of the next year. This means you can use your 2005 account balance until March 15, 2006. You have until June 30, 2006 to submit claims incurred between January 1, 2005 and March 15, 2006.

HOW THE OPTIONS WORK

During Open Enrollment, you estimate the amount you'll spend on unreimbursed health care and/or dependent care in the upcoming year. Using this estimate, you decide how much you want to contribute in before-tax dollars to the health care account and/or the dependent care account for the year.

When you incur an unreimbursed health care or dependent care expense, you pay it. Then you submit a claim to reimburse yourself for the expense with tax-free money from the appropriate account. You must accumulate \$5 in expenses before submitting a claim for reimbursement, unless it is year-end.

Many common health care expenses are eligible for reimbursement from your Health Care Flexible Spending Account, including medical and dental copayments, deductibles, prescriptions, and vision care for you and your eligible family members. Nonprescription, over-the-counter drugs, such as pain relievers, cold medicines, and allergy medicines, are eligible. Any nonprescription drugs that are not treating a specific medical condition or are preventive, such as vitamins and herbal and dietary remedies, are not eligible. As a general rule, any health care expense you could deduct on your federal income tax is eligible for reimbursement from your Health Care FSA. Please contact WageWorks for additional information.



If you know that you are terminating your employment during the year due to retirement or the completion of an appointment, you may designate the month and day you are leaving. If you make this designation during Open Enrollment, your contribution per paycheck will be the elected contribution divided by the number of paychecks prior to termination. If you do not designate a termination date, contributions will be calculated through December 31.

Eligible dependent care expenses include qualified day care centers for children (up to age 13) or adults, as well as care inside your home. You can use the Dependent Care Flexible Spending Account only if you are paying for dependent day care so you can work. In addition, if you are married, your spouse must work, attend school full-time at least five months each year or be disabled.

Before you elect to participate in Flexible Spending Accounts, you should be familiar with the rules that affect your participation.

These accounts have annual limits:

	Health Care FSA	Dependent Care FSA
Annual minimum	\$250 per year	Not applicable
Annual maximum	\$5,000 per year	\$5,000 per year \$1,900 per year for highly compensated employees

- Dependent Care Flexible Spending Account contributions are limited to \$1,900 on a pre-tax basis per year for highly compensated employees. In 2005 the IRS defined highly compensated employees as those who earned an annual salary of \$95,000 or more. For 2006, the IRS deemed those who earn \$100,000 or more annually to be highly compensated.
- If you have any amount left in your account(s) after March 15, 2006, you forfeit that money. However, if you plan carefully, you won't lose anything. (Even if you lose some money, you may still be ahead with the tax savings.)
- You may not transfer money between the accounts.
- Expenses reimbursed through a Flexible Spending Account cannot be used as a deduction or credit on your federal income taxes.



- Your 2006 contributions must be used for expenses you incur between January 1, 2006 and December 31, 2006, or if you are terminating employment prior to December 31, 2006, for the period in which you made contributions. However, if on December 31, 2006, your claims are less than your account balance, you may use claims incurred from January 1, 2006 until March 15, 2006 for reimbursement from your 2005 FSA. (You incur an expense on the date the service is provided, not when you are billed or when you pay for it.)

You must submit your claim by June 30 of the following year in order to receive reimbursement.

A Tax-Savings Example

Here's an example of how a spending account can help save you money you would otherwise pay in taxes. This example assumes you are married and have two children, your combined annual income is \$50,000 and you contribute \$2,500 to a health care spending account.

	With FSA	Without FSA
Combined Annual Income	\$50,000	\$50,000
FSA Contributions	- 2,500	- 0
Before-Tax Income	\$47,500	\$50,000
Income Taxes*	- 6,866	- 7,241
After-Tax Income	\$40,634	\$42,759
After-Tax Expenses	- 0	- 2,500
Take-Home Pay	\$40,634	\$40,259
FSA Tax Savings	\$375	\$0

* Estimates are based on 2005 tax tables and assume you are filing a joint tax return and take the standard deduction. State taxes have not been included but could represent additional savings if you would have otherwise paid state tax on the money you contribute to your spending account. The actual amount you save in taxes will depend on your personal situation.

Supplemental Retirement Program (SRP)



If you already participate in the Contributory Retirement Plan (CRP) or the Retirement Income Plan for Employees (ERIP) and would like to set aside additional money for your retirement through tax-deferred savings, you may want to take advantage of the Supplemental Retirement Program (SRP).

Under the SRP, you may voluntarily elect to contribute a specific dollar amount (subject to limitations imposed by law) each pay period to a TIAA-CREF retirement annuity or Vanguard custodial account. Your contributions are deducted from your pay before income taxes are calculated and will not be included as taxable income on your IRS Form W-2. This reduces the amount you owe in current income taxes.

Similarly, the investment earnings on your contributions are tax-deferred. You do not pay income taxes on your SRP accumulation until you begin to receive payments from the plan.

In exchange for this favorable tax treatment, the Internal Revenue Code limits the amount you may contribute to the SRP each calendar year. Beginning in 2007, the maximum contribution amount will be indexed in \$500 increments.

Did You Know?

It is not necessary to renew your SRP enrollment each calendar year. Your October 2005 contribution rate and percentage allocation between your TIAA-CREF and Vanguard accounts will automatically carry over into 2006 unless you otherwise elect to increase, decrease or stop your contributions or change your percentage allocation. In some cases, you may not want this automatic carryover to occur. Please see page 7 in *"The Supplemental Retirement Program: Enrollment Guide 2006."*

SRP enrollment is available on the Internet as part of Open Enrollment for all benefits-eligible employees. Those employees who do not enroll online may enroll by completing a paper salary reduction agreement, as in years past.

For more information, please refer to *"The Supplemental Retirement Program: Enrollment Guide 2006,"* available through the UHRM Web site at <http://hr.uchicago.edu>.



457(b) Deferred Compensation Plan

page 30

The 457(b) Deferred Compensation Plan is a nonqualified plan of deferred compensation available to a relatively small group of faculty and staff who satisfy the plan's eligibility requirements. The University does not contribute to the 457(b) Deferred Compensation Plan.

For more information, please refer to the “*457(b) Deferred Compensation Plan: Enrollment Guide 2006*,” available through the UHRM Web site at <http://hr.uchicago.edu>.

Monthly Rates for 2006



The following charts list your contribution rates for 2006 benefits.

- Monthly medical rates vary, depending on your full-time versus part-time status, salary, and coverage level (yourself only, yourself and one dependent, or yourself and your family).
- Your monthly dental rates depend on your coverage level.
- LTD, Group Life, and Personal Accident Insurance rates are based on formulas described on the following pages.

Medical Care Rates

FULL-TIME EMPLOYEES

	If your salary is:			
	Under \$37,000	\$37,000 – \$59,999	\$60,000 – \$89,999	\$90,000 or more
Maroon Plan				
■ Yourself only	\$76	\$94	\$120	\$156
■ Yourself and one dependent	\$125	\$168	\$207	\$246
■ Yourself and your family	\$162	\$215	\$265	\$315
UCHP				
■ Yourself only	\$29	\$44	\$59	\$68
■ Yourself and one dependent	\$62	\$94	\$134	\$162
■ Yourself and your family	\$78	\$114	\$161	\$192
Humana Premier HMO				
■ Yourself only	\$28	\$44	\$60	\$72
■ Yourself and one dependent	\$70	\$103	\$150	\$177
■ Yourself and your family	\$83	\$124	\$179	\$212
HMO Illinois				
■ Yourself only	\$25	\$41	\$54	\$62
■ Yourself and one dependent	\$61	\$90	\$131	\$155
■ Yourself and your family	\$76	\$112	\$162	\$191



PART-TIME EMPLOYEES

	If your salary is:			
	Under \$37,000	\$37,000 – \$59,999	\$60,000 – \$89,999	\$90,000 or more
Maroon Plan				
■ Yourself only	\$114	\$141	\$180	\$234
■ Yourself and one dependent	\$188	\$252	\$311	\$369
■ Yourself and your family	\$243	\$323	\$398	\$473
UCHP				
■ Yourself only	\$44	\$66	\$89	\$102
■ Yourself and one dependent	\$93	\$141	\$201	\$243
■ Yourself and your family	\$117	\$171	\$242	\$288
Humana Premier HMO				
■ Yourself only	\$42	\$66	\$90	\$108
■ Yourself and one dependent	\$105	\$155	\$225	\$266
■ Yourself and your family	\$125	\$186	\$269	\$318
HMO Illinois				
■ Yourself only	\$38	\$62	\$81	\$93
■ Yourself and one dependent	\$92	\$135	\$197	\$233
■ Yourself and your family	\$114	\$168	\$243	\$287

Medical Care Rates



Dental Care Rates

page 34

Dental Care Rates

	First Commonwealth Dental Plan	MetLife Dental Plan
Yourselves only	\$16.51	\$43.82
Yourselves and one dependent	\$31.59	\$85.48
Yourselves and your family	\$41.24	\$150.36



How to Calculate Your Monthly Rate	
<p>Step One</p> <p>Subtract the amount of coverage that the University pays (\$14,000 for full-time employees and \$7,000 for part-time employees) from your annual salary.</p>	<p>Example</p> <p>Jane Doe, a full-time employee, is 34 years old and earns \$25,840 per year. Here is how she calculates her contribution rate if she is choosing the:</p> <p>Base Plan: \$25,840 – \$14,000 = \$11,840</p> <p>Optional Plan: \$25,840 – \$14,000 = \$11,840</p>
<p>Step Two</p> <p>Multiply the result by the appropriate factor:</p> <ul style="list-style-type: none"> ■ .00619 if you have elected coverage under the Base Plan. ■ .00823 if you have elected coverage under the Optional Plan. 	<p>Base Plan</p> <p>\$11,840 x .00619 = \$73.29</p> <p>Optional Plan</p> <p>\$11,840 x .00823 = \$97.44</p>
<p>Step Three</p> <p>Divide the result by 12. This gives you your monthly LTD contribution rate.</p>	<p>Base Plan</p> <p>\$73.29 ÷ 12 = \$6.11</p> <p>Jane will pay \$6.11 per month for the Base Plan.</p> <p>Optional Plan</p> <p>\$97.44 ÷ 12 = \$8.12</p> <p>Jane will pay \$8.12 per month for the Optional Plan.</p>

The table below shows some examples of monthly LTD contribution rates for various salaries (based on full-time employment):

Annual Salary	Base Plan	Optional Plan
\$15,000	\$0.52	\$0.69
\$20,000	\$3.10	\$4.12
\$25,000	\$5.67	\$7.54
\$35,000	\$10.83	\$14.40
\$50,000	\$18.57	\$24.69
\$75,000	\$31.47	\$41.84
\$100,000	\$44.36	\$58.98



Group Life Insurance Rates

The University provides basic life insurance at no cost to you. You may purchase additional coverage.

How to Calculate Your Monthly Rate	
<p>Step One Start with the full amount of your coverage (one, two, three or four times your salary) and round up to the nearest thousand. Remember, the maximum is \$1,000,000, and a Statement of Health is needed if you elect an amount over \$600,000.</p>	<p>Example Jane Doe, a full-time employee, is 34 years old and earns \$25,840 per year. She has elected life insurance coverage equal to two times her annual salary: $2 \times \\$25,840 = \\$51,680$ Round up to nearest \$1,000 = \$52,000</p>
<p>Step Two Subtract the amount of coverage that is paid by the University (\$12,000 if you are full-time, and \$6,000 if you are part-time).</p>	<p>$\\$52,000 - \\$12,000 = \\$40,000$</p>
<p>Step Three Divide the rest by \$1,000.</p>	<p>$\\$40,000 \div \\$1,000 = 40$</p>
<p>Step Four Multiply that figure by the appropriate factor from the table below.</p>	<p>$40 \times \\$0.040 = \\1.60 Jane will pay \$1.60 per month for \$52,000 of life insurance coverage.</p>

When you are calculating your monthly rate, refer to the chart below for the appropriate factor.

Your Age	Monthly Factor per \$1,000 of Coverage
Less than 35	\$0.040
35 – 39	\$0.050
40 – 44	\$0.090
45 – 49	\$0.150
50 – 54	\$0.230
55 – 59	\$0.430
60 – 64	\$0.650
65 – 69*	\$1.200
70 – 74*	\$2.060
75 and over*	\$2.060

*Reduction in coverage applies; see page 24.

Personal Accident Insurance Rates



How to Calculate Your Monthly Rate	
Step One Choose the amount of coverage you want.	Example Jane wants to know what it would cost if she chooses coverage equal to \$80,000 for herself only or for herself and family.
Step Two Divide the amount of your total coverage ("your principal amount") by \$10,000.	$\$80,000 \div \$10,000 = 8$
Step Three Multiply the result by the appropriate rate: ■ \$.22 if you have coverage for yourself only ■ \$.32 if you have coverage for yourself and your family This gives you your monthly contribution rate.	$8 \times \$.22 = \1.76 Jane will pay \$1.76 per month for coverage for herself. $8 \times \$.32 = \2.56 Jane will pay \$2.56 per month for family coverage.

The table below shows some examples of monthly Personal Accident Insurance contribution rates for various coverage levels:

Principal Amount	Cost of Individual Coverage (Yourself Only)	Cost of Family Coverage (Yourself and Your Family)
\$50,000	\$1.10	\$1.60
\$100,000	\$2.20	\$3.20
\$150,000	\$3.30	\$4.80
\$200,000	\$4.40	\$6.40
\$250,000	\$5.50	\$8.00
\$300,000	\$6.60	\$9.60
\$350,000	\$7.70	\$11.20
\$400,000	\$8.80	\$12.80
\$450,000	\$9.90	\$14.40
\$500,000	\$11.00	\$16.00



Additional Benefits

page 38

You may be eligible for a number of additional benefits, which are described briefly in the following pages. You may contact the Benefits Office at (773) 702-9634 or benefits@uchicago.edu or visit the UHRM Web site at <http://hr.uchicago.edu> for additional information, including applications, on any of these benefits.

Benefits That Require an Application



Type of Benefit	Description
Retirement Benefits	<p>Retirement Income Plan for Employees (ERIP) <i>Mandatory for benefits-eligible non-academic employees who have completed one year of service <u>and</u> reached age 21</i></p> <p>The Retirement Income Plan for Employees (ERIP) is designed to provide retirement income for benefits-eligible non-academic employees of the University.</p> <p>ERIP consists of two parts. The “defined benefit” part provides lifetime retirement income to participants who have at least three years of service with the University; the amount of the benefit is determined by a formula that takes into account the participant’s average salary and years of plan participation. The defined benefit is funded entirely by the University.</p> <p>Under the “defined contribution” part of the plan, each participant establishes an individual account with TIAA-CREF and/or Vanguard through which retirement contributions are invested at his or her direction. The participant contributes 3% of pre-tax earnings each pay period and the University contributes 2.5%. Earnings on the contributions are tax-deferred, so no taxes are payable until the participant actually begins to receive benefits. Participants with a hire date before July 1, 2005 are always 100% vested in their defined contribution account. Participants with a hire date after June 30, 2005 are always 100% vested in their employee contributions; they are 100% vested in the University’s contributions upon completing three years of service.</p> <p>To find out how your contributions are invested within TIAA-CREF or Vanguard, please contact TIAA-CREF at (800) 842-2776 or Vanguard at (800) 523-1188.</p>

Benefits That Require an Application



Benefits That Require an Application

Type of Benefit	Description
<p>Retirement Benefits (continued)</p>	<p>Contributory Retirement Plan (CRP) <i>Mandatory upon appointment for full-time, benefits-eligible academic employees; mandatory upon completion of one year of service in the position for part-time, benefits-eligible academic employees; mandatory for highly compensated, benefits-eligible non-academic employees</i></p> <p>The Contributory Retirement Plan (CRP) is designed to provide retirement income for benefits-eligible academic employees of the University. Under CRP, each participant establishes an individual account with TIAA-CREF and/or Vanguard through which retirement contributions are invested at his or her direction. The participant contributes 5% of compensation (excluding certain extra service pay) each pay period and the University contributes 8.0%. Earnings on the contributions are tax-deferred, so no taxes are payable until the participant actually begins to receive benefits.</p> <p>Participants with a hire date before July 1, 2005 are always 100% vested in their CRP account. Participants with a hire date after June 30, 2005 are always 100% vested in their employee contributions; they are 100% vested in the University's contributions upon competing three years of service.</p> <p>To find out how your contributions are invested within TIAA-CREF or Vanguard, please contact TIAA-CREF at (800) 842-2776 or Vanguard at (800) 523-1188.</p>
<p>Insurance Benefits</p>	<p>Long-Term Care Insurance <i>Available to all University employees</i></p> <p>The University offers employees, spouses, parents, and parents-in-law the opportunity to purchase long-term care insurance through John Hancock at a discount. This coverage can help offset the cost of nursing home care, home health care, and adult day care.</p>
<p>Other Benefits</p>	<p>Educational Assistance Program <i>Available to all full-time, benefits-eligible University employees</i></p> <p>The program gives you and/or your dependents several tuition reimbursement options. The options vary depending on whether you are an academic or non-academic employee.</p> <hr/> <p>Qualified Transportation Program (QTP) <i>Available to all benefits-eligible University employees</i></p> <p>The Qualified Transportation Program gives you options to pay for certain commuting expenses on a pre-tax basis depending on how you commute to work.</p>

Benefits That Do Not Require an Application



Type of Benefit	Description
Other Benefits	<p>Travel Accident Insurance Program <i>Available to all University employees</i></p> <p>The Travel Accident Insurance Program provides a benefit if you die or suffer a serious injury in an accident while traveling on University business away from University premises. Generally, you are covered for five times your pay, from \$50,000 to \$500,000. Your participation automatically begins on your first day of work. The University pays the full cost.</p>
	<p>Staff and Faculty Assistance Program <i>Available to all benefits-eligible University employees and their families</i></p> <p>The Staff and Faculty Assistance Program is a confidential and professional service designed to help you or your family when you need assistance with personal life issues. Services are provided at no cost to you by Perspectives Ltd., and include evaluation, counseling, and referral services. If you need a treatment program or additional services, Perspectives will work with you to obtain the best care as inexpensively as possible. You may contact Perspectives at (800) 456-6327.</p>
	<p>Child Care Referral Programs <i>Available to all benefits-eligible University employees and graduate students</i></p> <p>The University of Chicago provides two child care referral services for parents. The University provides both of these resources at no charge to you, but you are responsible for the cost of the day care services you decide to use.</p> <p>(1) Child Care Resource and Referral Service You can call the Resource and Referral Service at (773) 564-8890 to speak with a trained counselor about your child care needs. He or she can help you locate and evaluate:</p> <ul style="list-style-type: none"> ■ Day care for infants and pre-school children ■ Before and after-school care for school-age children, or ■ Summer programs for school-age children. <p>(2) Child Care Packet Available in Benefits Counseling Office The Benefits Counseling Office can provide you with a listing of child care providers in the University community or register you if you wish to work as a child care provider.</p>

Benefits That Do Not Require an Application



Type of Benefit	Description
Other Benefits (continued)	<p>Elder Care Consultation and Referral Service <i>Available to all benefits-eligible University employees, retirees and their families</i></p> <p>The University of Chicago provides an elder care referral service designed to assist you in making elder care arrangements. You may call (630) 789-8585 for elder care information, referrals, expertise, and support. The University provides the referral service at no charge to you, but you are responsible for the elder care services you decide to use.</p>

This brochure provides an overview of your University of Chicago benefit plans. It is for informational purposes only. It is neither intended to be an agreement for continued employment, nor is it a legal plan document. If there is a discrepancy between this brochure and the plan documents, the plan documents will govern. In addition, the plans described in this brochure are subject to change without notice. Continuation of benefits is at the University's discretion.

© Copyright 2005 The University of Chicago