

2020

# Retiree Medical Plan



THE UNIVERSITY OF  
**CHICAGO**

Human  
Resources

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**If you and/or your dependent have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 18 for more details.**

Dear Retiree Medical Plan Participant:

This Retiree Medical Plan Guide provides you with information regarding your medical and prescription drug coverage **effective January 1, 2020**. This guide also contains important information about your rights and responsibilities.

- If you are **eligible for Medicare**, you have the choice of a Medicare Advantage Plan or a Medicare Supplement Plan, both administered by Aetna. Your prescription drug coverage will continue to be provided by the current plan administrator, Express Scripts.
- If you are **not eligible for Medicare**, your medical coverage will continue to be provided through a Preferred Provider Organization (PPO) plan administered by Blue Cross and Blue Shield of Illinois (BCBSIL). Your prescription drug coverage will continue to be provided by the current plan administrator, Express Scripts.

Those eligible for Medicare will receive additional information from Aetna in the coming weeks.

## Questions?

If you have questions, please call a Benefits Specialist Monday through Friday from 8:30 a.m. to 4:30 p.m. CST at **855.822.8901**, or send an email to [retiree@uchicago.edu](mailto:retiree@uchicago.edu).

Sincerely,

*Elizabeth Walls*

Elizabeth Walls  
Director of Health, Welfare, and Retirement  
Human Resources

## Eligibility for the Retiree Medical Plan

The Retiree Medical Plan is available to employees who retire from the University who were either:

- Employed prior to January 1, 2005, in a continuous benefits-eligible position and are at least age 55 when employment terminates; or
- Employed on or after January 1, 2005, are at least age 55, and have completed at least 10 years of continuous benefits-eligible service when employment terminates.

# Staff and Faculty Assistance Program

The University of Chicago offers a Staff and Faculty Assistance Program (SFAP) through Perspectives Ltd., to help you and your family members manage the challenges of daily living. As a retiree, you are eligible for this program.

This confidential program provides support, counseling, referrals, and resources for all life issues — at no cost to you. Assistance is provided by professional master's level counselors and specialists.

SFAP is available 24 hours a day, 7 days a week and can be accessed three ways:

- By phone: 800.456.6327.
- In person, by appointment only: call 800.456.6327 to schedule an appointment.
- Online: [perspectivesltd.com](https://perspectivesltd.com) (user name: UNI500; password: perspectives).



# Your Medical Benefits: An Overview

The following chart shows medical plan coverage based on your Medicare eligibility.

	Eligible for Medicare	Not Eligible for Medicare
<b>Who is Eligible</b>	<ul style="list-style-type: none"> <li>• Retirees and their eligible dependents age 65 or older</li> <li>• Retirees and their eligible dependents who became disabled* before age 65 and are determined to be Medicare-eligible</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees and their eligible dependents younger than age 65</li> <li>• Retirees living outside of the United States</li> </ul>
<b>Medical Plan</b>	<ul style="list-style-type: none"> <li>• Choice of two Retiree Medical Plans administered by Aetna</li> </ul>	<ul style="list-style-type: none"> <li>• Retiree Medical Plan administered by Blue Cross and Blue Shield of Illinois (BCBSIL)</li> </ul>
<b>For More Information</b>	<ul style="list-style-type: none"> <li>• See page 4</li> </ul>	<ul style="list-style-type: none"> <li>• See page 10</li> </ul>

\*Disabled people who are approved for Social Security Disability Insurance (SSDI) benefits will receive Medicare.

## Split Families

You and your eligible dependents may be enrolled in different medical plans based on your Medicare eligibility. For example, you may be eligible for Medicare while your spouse is not eligible, or vice versa. In these situations, the family member who is eligible for Medicare will be covered by the Aetna Retiree Medical Plan selected. The family member who is not eligible for Medicare will be covered by the BCBSIL PPO.

### New Carrier for Medicare-eligible Retirees

The University heard your concerns about the 2019 Anthem coverage. This summer, the Provost-appointed *Working Group on the Retiree Medical Plan* reviewed the 2019 plan and retiree experience and made a number of recommendations for changes to coverage. We are pleased to offer a new carrier and two coverage options for 2020, in accordance with their recommendations.

# Medical Benefits If You Are Eligible

The University offers Medicare-eligible retirees the choice of two medical plans, both administered by Aetna: the Medicare Advantage Plan or the Medicare Supplement Plan. Aetna is a top carrier in the Medicare space and offers a strong provider network. In order to ensure continuity of coverage, **you will be enrolled automatically in the Medicare Advantage Plan effective January 1, 2020.** If you prefer coverage under the Medicare Supplement Plan, complete and return the enrollment form included in this package by November 30, 2019, to the Benefits Office. You will only be able to change plans each year during Open Enrollment.

## Understanding the Medicare Advantage Plan vs Medicare Supplement Plan

There are key differences in how the Medicare Advantage Plan and the Medicare Supplement Plan work, including how claims are filed and paid. Review the chart below:

Aetna Medicare Advantage Plan	
<b>Overview of the plan</b>	<ul style="list-style-type: none"> <li>The Aetna Medicare Advantage Plan is a Medicare Part C plan that includes both Medicare Part A (hospital insurance) and Part B (medical insurance).</li> <li>Coverage under the Medicare Advantage Plan means you still have Medicare, but your insurance coverage is managed and paid for by Aetna.</li> </ul>
<b>How Aetna works with Medicare</b>	<ul style="list-style-type: none"> <li>Aetna, not Medicare, is the primary and only payer for your medical care; you are still part of the federal Medicare program.</li> <li><b>Your medical services must be provided by a doctor who accepts Medicare.</b></li> </ul>
<b>When you get care</b>	<ul style="list-style-type: none"> <li>Present your Aetna ID card; <b>do not use your Medicare card.</b></li> <li>Retain your Medicare card in case you participate in hospital-based research studies or need to obtain hospice services.</li> </ul>
<b>Submitting claims and paying your provider</b>	<ol style="list-style-type: none"> <li>Pay your provider the applicable copay.</li> <li>Your provider will file your claim with Aetna.</li> <li>Aetna processes your claim directly with Medicare. The claim will be processed using your Medicare Part A and B benefits.</li> <li>You will receive an Explanation of Benefits (EOB).</li> <li>Pay your provider directly for the portion of the cost (if any) <b>only after you have received</b> both your EOB and your provider's bill. Sometimes providers send bills right away, but you should wait for the next bill that comes after you have received your EOB.</li> </ol>

# for Medicare

## Take note

### Informed Health<sup>®</sup> Line

With the Informed Health<sup>®</sup> Line, you can speak to a registered nurse about health issues 24 hours a day, 7 days a week by calling 800.556.1555.

## Aetna Medicare Supplement Plan

- The Medicare Supplement Plan coordinates payments with Medicare Part A and B and supplements the Medicare coverage by paying additional amounts not covered.
  - Medicare provides your primary medical coverage and pays first.
  - The Aetna Medicare Supplement Plan will process second and pay additional amounts not covered by Medicare.
- 
- **Your medical services must be provided by a doctor who accepts Medicare.**
  - Aetna will process your claim under the terms of the Retiree Medical Plan once it knows the amount that Medicare has covered and paid.
- 
- Present your red, white, and blue Medicare ID card **and** Aetna ID card.
- 
1. Your provider will file your claim with Medicare.
  2. You will receive a Medicare Summary Notice (MSN) showing how much Medicare pays and how much you owe; you do not need to pay until after Aetna processes the claim.
  3. The claim submitted to Medicare is automatically sent to Aetna for processing. The Aetna Medicare Supplement Plan may help pay for some or all of the costs not paid by Medicare.
  4. You will receive an Explanation of Benefits (EOB) showing how much Aetna paid and how much you may owe.
  5. After your claim has gone through both Medicare and Aetna, you will receive a bill from your provider for any remaining amount.
  6. Pay your provider directly for the portion of the cost (if any) **only after you have received** both your MSN and EOB. Sometimes providers send bills right away, but you should wait for the next bill that comes after you have received your MSN and EOB.

# The Aetna Medicare Plans

## Compare the Plans

Below is a side-by-side comparison of the key elements under each plan. Coverage levels marked in **blue** indicate a benefit enhancement and coverage levels marked in **red** indicate a lesser benefit than provided in the current plan.

Plan Provision	Aetna Medicare Advantage Plan	Aetna Medicare Supplement Plan
<b>Deductible per individual</b>	<b>\$150</b>	\$300
<b>Out-of-pocket maximum per individual</b>	<b>\$1,000 (includes deductible, copays and coinsurance)</b>	\$1,750 (includes deductible and coinsurance)
<b>Office visits</b> (Primary Care Physician/Specialist)	<b>\$10/\$35</b> copay after the deductible	<b>10% coinsurance after the deductible</b>
<b>Preventive care</b>	100% covered	100% covered
<b>Lab work</b>	100% covered after the deductible	100% covered after the deductible
<b>X-rays</b>	<b>\$35 copay after the deductible</b>	<b>10% coinsurance after the deductible</b>
<b>Durable medical equipment</b>	10% coinsurance after the deductible	<b>10% coinsurance after the deductible</b>
<b>Inpatient hospital</b>	\$250 copay per admission after the deductible	\$250 copay, then <b>10% coinsurance</b> after the deductible
<b>Outpatient hospital</b>	<b>\$50 copay after the deductible</b>	<b>10% coinsurance after the deductible</b>
<b>Urgent care</b>	\$65 copay	<b>10% coinsurance to maximum \$65 copay</b>
<b>Emergency room</b>	\$100 copay	10% after the deductible
<b>Prior authorization</b>	May be required	<b>Not required</b>
<b>Additional benefits/coverage</b>	<ul style="list-style-type: none"> <li>• SilverSneakers® fitness program</li> <li>• Routine vision care</li> <li>• Routine hearing services</li> <li>• Hearing aid coverage</li> <li>• Video doctor visits (telemedicine)</li> <li>• Routine foot care</li> </ul>	Member discount program available that provides discounts on services such as vision services and hardware, fitness and hearing aids

### Take note

Be sure to confirm that your providers accept Medicare assignments before receiving services. Aetna cannot pay a provider that does not accept or has opted out of Medicare. If you receive care from one of these providers, you will be responsible for the full medical bill without reimbursement.



## Finding In-Network Providers

From a claims standpoint, it is always better to see an in-network provider, no matter which plan you choose. To find an in-network provider or confirm if your provider is in-network:

- **Call Aetna's Member Services at 888.267.2637.** Representatives are available Monday through Friday from 8:00 a.m. to 6:00 p.m. local time. You can also request that a copy of the Aetna Provider Directory be mailed to you.
- **Go online to [aetnaretireeplans.com](http://aetnaretireeplans.com).** You can review the *Step-by-Step Aetna Provider Search Instructions* found on the Benefits website (see contacts on page 17).

## Care When Traveling Outside the U.S.

If you are traveling outside the country, you are covered for urgent and emergency care. Contact Aetna Member Services at 888.267.2637 for assistance with finding a provider or care facility. You will need to pay the costs up front and then submit paid receipts to Aetna directly for reimbursement.

## Moving from Anthem Medicare Advantage Plan to Aetna

When the Centers for Medicare and Medicaid Services (CMS) is informed that the University is changing carriers (moving from Anthem to Aetna), you will receive a letter from Anthem informing you that your Medicare Advantage coverage has been terminated. **There is nothing you need to do;** this is a letter that Medicare requires when coverage changes.

- If you stay enrolled in the Aetna Medicare Advantage Plan, you will receive a Medicare-required letter from Aetna in December 2019 about your new coverage, an enrollment kit, and a new ID card.
- If you elect the Aetna Medicare Supplement Plan, you will not receive a letter from Aetna because the Medicare Supplement Plan is outside of Medicare; however, you will receive a new ID card.

Note: Because the Medicare Supplement Plan is a simpler plan with fewer rules, you will not receive as many detailed communications from Aetna.

## Medicare Part D Prescription Coverage

Your Medicare Part D prescription drug coverage will continue to be administered by Express Scripts. The Aetna Medicare Plans do not include Medicare Part D prescription drug coverage.

For information on your prescriptions or to find an Express Scripts participating retail network pharmacy near you, visit [express-scripts.com](http://express-scripts.com). You can also call Express Scripts Customer Service at 866.838.3979 (age 65 and over) or 800.935.7189 (under age 65). See page 14 for more details on your prescription drug coverage.

Note: The University does not require a separate prescription drug premium. However, the Social Security Administration may require an Income Related Monthly Adjustment Amount, as required under the Affordable Care Act, for some retirees based on their income. If you are required to pay an extra amount, the Social Security Administration will send you a letter listing the extra amount and how to pay it.

# Aetna Medicare Advantage Plan

## Using Out-of-Network Providers

While the Aetna Medicare Advantage Plan network is strong and your providers are likely in-network, you may find that you want to see an out-of-network provider. The Aetna Medicare Advantage Plan has an Extended Service Area (ESA) that allows you to see out-of-network providers as long as they accept Medicare.

## Continuity of Care

A change in health plan should not mean a change in care. Aetna provides care coordination for you if you have any planned surgery or tests scheduled for January 2020. Complete a *Continuity of Care Transition Assistance Form* available on the Benefits website (see contacts on page 17).

## Prior Authorization

In some cases, your doctor may need to get approval in advance from Aetna for certain types of services or tests. This is called prior authorization. If you are using an in-network provider, the provider is responsible for obtaining prior authorization. Services and items requiring prior authorization are listed in the Evidence of Coverage.

Prior authorization is not required to see an out-of-network provider, but you may want to ensure that your out-of-network provider obtains prior authorization for services.

## Understanding Your Explanation of Benefits (EOB)

Your Explanation of Benefits (EOB) provides information about your medical claims – such as your doctor visits, hospital stays, how much Medicare pays, and any amounts you may owe your provider.

The Aetna Medicare Advantage Plan EOB has three sections:

- **Payment Summary:** Shows all payments that Aetna paid to the provider
- **Details for Claims Processed:** Shows the claim details, including amount billed, amount paid, and the amount (if any) you owe
- **Yearly Limits:** Provides details on your annual limits so that you can track your out-of-pocket costs

For additional details on the EOB, go to the Benefits website (see contacts on page 17) and click on *Understanding Your Medicare Advantage Part C Explanation of Benefits (EOB)*.

# Aetna Medicare Supplement Plan

## How to Access Care

The Aetna Medicare Supplement Plan allows you to have more control of your health. You can visit any doctor or hospital as long as they accept Medicare. It is always easier to visit in-network providers because they already have a relationship with Aetna, but it is not necessary when using the Medicare Supplement Plan. In addition, **there are no prior authorization requirements**. As long as Medicare processes the claim, Aetna will pay the supplemental amount per the plan guidelines.

## Medicare Direct

If you are enrolled in the Medicare Supplement Plan, Medicare Part A and/or B pays first for your claims. A second claim is then sent to Aetna to pay for any covered remaining balance. Medicare Direct saves you the trouble of filing a second claim. With Medicare Direct, Medicare will automatically forward any remaining expenses to Aetna for processing.

You will be enrolled automatically in Medicare Direct as long as Aetna has your Medicare ID number. The University will provide this information to Aetna.

## Selecting Your Medical Plan

Choosing the medical plan that is right for you is important. In addition to understanding the differences between the Medicare Advantage Plan and the Medicare Supplement Plan, consider the following:

### What is the cost of the plan?

For the Medicare Advantage Plan, your cost is \$254 per month for individual coverage, compared to \$345 per month for individual coverage in the Medicare Supplement Plan.

### What are my out-of-pocket costs?

You should consider the deductible amounts for each plan, as well as the copay and coinsurance for services (see details in the plan comparison chart on page 6). The Medicare Advantage Plan has a lower deductible and lower annual out-of-pocket maximum amount than the Medicare Supplement Plan.

### How do I know if my doctor is in-network?

Aetna is a top carrier in the Medicare space and offers a strong provider network. You can look up providers at [aetnaretireplans.com](http://aetnaretireplans.com).

### What if my provider is not in-network or does not accept Medicare Advantage?

You may want to consider the Medicare Supplement Plan, which gives you the freedom to see any provider who accepts Medicare. Aetna will pay the supplemental amount per the plan guidelines.

### Can I access extra programs or benefits, such as SilverSneakers®?

Yes, if you select the Medicare Advantage Plan. This is not available with the Medicare Supplement Plan; however, other discount programs are available.

# Medical Benefits If You Are NOT Eligible for Medicare

If you are not eligible for Medicare, the Retiree Medical Plan provides medical coverage with Blue Cross Blue Shield of Illinois. This coverage may continue until you become eligible for Medicare, at which time you can select either the Aetna Medicare Advantage Plan or the Aetna Medicare Supplement Plan.

The medical plan is administered by Blue Cross and Blue Shield of Illinois (BCBSIL) and is a Preferred Provider Organization (PPO) plan. BCBSIL offers a large network of contracting doctors and hospitals to choose from when care is needed. The Retiree Medical Plan will pay for eligible expenses, such as routine physical exams and health care services provided outside the United States. To find a network provider, call BCBSIL at 866.390.7772 or visit [bcbsil.com/providers](https://bcbsil.com/providers).

## When You Get Care

<b>Show your ID card</b>	<ul style="list-style-type: none"> <li>• Present your BCBSIL Retiree Medical Plan ID card to providers.</li> </ul>
<b>The claim is automatically sent to BCBSIL for processing</b>	<ul style="list-style-type: none"> <li>• Your in-network provider automatically sends your claim to BCBSIL for processing.</li> <li>• You will receive an Explanation of Benefits (EOB) showing how much the plan pays and how much you may owe.</li> </ul>
<b>Wait for the bill from your provider</b>	<ul style="list-style-type: none"> <li>• After your claim has gone through BCBSIL, you will receive a bill from your provider for any remaining amount.</li> <li>• Pay your provider directly for your portion of the cost (if any) only <b>after you have received</b> your EOB. Sometimes providers send bills right away; however, you should wait to receive your EOB before you pay your bill.</li> </ul>

## At a Glance: Not Eligible for Medicare (BCBSIL PPO)

Plan provision	You pay In-network	You pay Out-of-network
<b>Annual Deductible<sup>1</sup></b>	\$300	\$300
<b>Annual Out-of-Pocket Maximum</b> (Does not include annual deductible or prescription copays)	\$1,750	\$1,750
<b>Preventive Care / Wellness</b>	No charge; deductible does not apply	
<b>Physician Office Visits</b> (non-preventive services)	20% coinsurance, after the deductible	35% coinsurance <sup>3</sup> , after the deductible
<b>Lab Work, X-rays</b>	20% coinsurance, after the deductible	35% coinsurance <sup>3</sup> , after the deductible
<b>Hospital Services<sup>2</sup></b> <b>Inpatient<sup>2</sup></b> (Prior authorization required for planned procedures)	\$0 copayment per admission, 20% coinsurance, after the deductible	\$200 copayment per admission, 35% coinsurance <sup>3</sup> , after the deductible
<b>Outpatient<sup>2</sup></b> (Prior authorization required for certain planned procedures)	20% coinsurance, after the deductible	35% coinsurance <sup>3</sup> , after the deductible
<b>Emergency Room</b>	20% coinsurance, after the deductible	20% coinsurance, after the deductible
<b>Urgent Care</b>	20% coinsurance, after the deductible	35% coinsurance <sup>3</sup> , after the deductible

<sup>1</sup> Any expenses applied to your deductible during October, November, or December can carry over into the next year.

<sup>2</sup> If your doctor recommends overnight hospitalization, you must call BCBSIL at 800.635.1928 in advance for approval. If you do not call and receive approval, you will pay an additional \$250 for that admission. In case of an emergency, you or a family member must make the call within 48 hours of admission.

<sup>3</sup> Plan pays 65% of the BCBSIL prevailing fee schedule for out-of-network providers. In addition to the 35% you pay for out-of-network providers, you are also responsible for 100% of the charges in excess of the prevailing fee schedule.

## Hospital Services

If your doctor recommends an overnight hospitalization, call BCBSIL at 800.635.1928 for prior approval. **If you do not call in advance and receive approval, you will pay an additional \$250 for that admission.** In case of an emergency, you or a family member must make the call within 48 hours.

## Care When Traveling Outside the U.S.

The Retiree Medical Plan provides medical assistance services, doctors, and hospitals when traveling outside the United States. If you need to locate a doctor or hospital, or need medical assistance services, call the BCBS Global Core (BGC) Service Center at 800.810.2583 or call collect at 804.673.1177, 24 hours a day, 7 days a week.

In an emergency, go directly to the nearest hospital. If hospitalized (admitted), call the BGC Service Center. For non-emergency inpatient medical care, you must contact the BGC Service Center to arrange for care from a BGC hospital.

You pay 100% of the charges directly to the physician or hospital at the time services are received, and the Plan will reimburse you 80% for covered expenses.

You pay up front and then complete a BGC International claim form and send it with the itemized bill(s) for all services to the BGC Service Center. BGC claim forms are available at [bcbsglobalcore.com](http://bcbsglobalcore.com). You are responsible for 100% of all non-covered services.

## 24/7 Nurseline

Nurseline is available 24 hours a day, 7 days a week to answer your health-related questions at no charge. Call 800.299.0274 to be connected with a registered nurse who can provide accurate, confidential health information about a multitude of health conditions.



# Prescription Drug Benefits

You are automatically enrolled in the prescription drug program administered by Express Scripts. Express Scripts has more than 68,000 participating network pharmacies nationwide for your retail prescription needs, plus convenient mail order/home delivery service.

## Purchasing Your Prescriptions

The prescription drug plan classifies prescription drugs into four coverage tiers:

- **Generic drugs** are therapeutically equivalent to brand-name drugs, must be approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness, and cost less.
- **Preferred brand drugs** are safe, effective alternatives to non-preferred brands. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any change limits your ability to fill a prescription, you will be notified before the change is made.
- **Non-preferred brand drugs** are typically higher-cost and/or newer drugs that have recently come on the market and are more expensive.
- **Specialty drugs** are used to treat a specific condition and may require member-specific dosing, medical devices to administer the medication, and/or special handling and delivery.

What you pay for prescription drugs will depend on the type of drug (generic, preferred brand, non-preferred brand, or specialty), whether you buy your prescriptions at a retail pharmacy or through home delivery/mail order service, and whether you use an in-network pharmacy.

Prescription Drugs	Express Scripts Retail Pharmacy (31-day supply)	Express Scripts Home Delivery/ Mail Order Pharmacy (90-day supply)	Express Scripts Retail Pharmacy (90-day supply)
<b>Generic Copay</b>	You pay \$10	You pay \$20	You pay \$30
<b>Preferred Brand Copay</b>	You pay \$30	You pay \$60	You pay \$90
<b>Non-Preferred Brand Copay</b>	You pay \$50	You pay \$100	You pay \$150
<b>Specialty Copay</b>	You pay \$75	You pay \$150	You pay \$225



## Prescription Drug ID Cards

When you first enroll in Retiree Medical, you will receive a separate Express Scripts ID card for your prescription drug benefits.

- Each member enrolled in the Medicare Part D program will have a unique member ID number and card.
- Spouses and dependents who are under age 65 will receive a separate ID card addressed to the retiree with the retiree's name on the ID card.

## Where to fill your prescriptions

<b>Retail Pharmacy</b>	<p>Generally used to fill short-term prescriptions for temporary conditions. Short-term prescriptions are for a 31-day supply or less. Visit a participating retail pharmacy and present your Express Scripts ID card and prescription.</p> <p>To find an Express Scripts participating retail network pharmacy in your area, visit <a href="https://www.express-scripts.com">express-scripts.com</a>.</p>
<b>Home Delivery/ Mail Order Service</b>	<p>Generally used to fill long-term maintenance prescriptions for ongoing conditions, such as asthma, diabetes, and high blood pressure. Home delivery/mail order service is a convenient and cost-effective way to order up to a 90-day supply. To use home delivery/mail order:</p> <ul style="list-style-type: none"> <li>• Complete a home delivery order form and submit it along with a 90-day prescription from your doctor. Register as a member at <a href="https://www.express-scripts.com">express-scripts.com</a> to print a copy of the form.</li> <li>• If your doctor is submitting the mail order prescription on your behalf, your doctor will need to fax your 90-day prescription along with your member ID number, which is located on the front of your Express Scripts member ID card, to Express Scripts at 800.837.0959.</li> </ul>

### Take note

The University does not require a separate prescription drug premium. However, the Social Security Administration may require an Income Related Monthly Adjustment Amount, as required under the Affordable Care Act, for some retirees based on their income from two years ago. If you are required to pay an extra amount, the Social Security Administration will send you a letter listing the extra amount and how to pay it.

# Retiree Medical Plan Premiums

Monthly rates for the Retiree Medical Plan vary depending on the number of people who are being covered, their ages, and whether or not they are enrolled in Medicare Parts A and B. Monthly premiums will be adjusted as shown below.

<b>When you take the following actions (premiums reflect the lower, 65-and-older rate)</b>	<ul style="list-style-type: none"> <li>Call 800.772.1213 to enroll in Medicare Parts A and B three months prior to your 65th birthday, and</li> <li>Send a copy of your Medicare card showing Part A and Part B coverage to:               <div style="margin-left: 40px;">                 Mail: Human Resources - Benefits                  Attention: Retiree Medical Plan                  6054 S. Drexel Ave.                  Chicago, IL 60637               </div> <div style="margin-left: 40px;">                 Email: <a href="mailto:retiree@uchicago.edu">retiree@uchicago.edu</a>                  Fax: 773.834.0996               </div> </li> </ul>
<b>Upon the death of a retired employee or dependent</b>	<ul style="list-style-type: none"> <li>Call 855.822.8901 to notify the Benefits Office of the death.</li> <li>Premium adjustment will become effective the first of the month following the date of death.</li> </ul>

## Monthly Premiums Effective January 1, 2020

Level of coverage	Aetna Medicare Advantage Plan	Aetna Medicare Supplement Plan	BCBSIL PPO
One person under age 65			\$658
One person age 65 or older	\$254	\$345	
One person age 65 or older and one person under age 65	\$912	\$1,003	
Two persons under age 65			\$1,316
Two persons age 65 or older	\$508	\$689	
Three or more persons all under age 65			\$1,974
Three or more persons, including one person age 65 or older	\$1,570	\$1,661	
Three or more persons, including two persons age 65 or older	\$1,166	\$1,347	

# Contacts

	Customer Service Number	Address
University of Chicago Human Resources Benefits Office	<b>Phone:</b> 855.822.8901 <b>Fax:</b> 773.834.0996 <b>Email:</b> <a href="mailto:retiree@uchicago.edu">retiree@uchicago.edu</a> <b>Website:</b> <a href="https://humanresources.uchicago.edu/benefits/">https://humanresources.uchicago.edu/benefits/</a>	6054 S. Drexel Ave. Chicago, IL 60637
Aetna Medical Plans — Eligible for Medicare	<b>Pre-enrollment Services:</b> 800.307.4830	N/A
Aetna Medicare Advantage Plan	<b>Member Services (8 a.m. - 6 p.m.):</b> 888.267.2637	PO Box 981106 El Paso, TX 79998-1106
Aetna Medicare Supplement Plan	<b>Member Services (24 hours):</b> 888.982.3862	PO Box 981106 El Paso, TX 79998-1106
Blue Cross and Blue Shield of Illinois — Medical Plan Not Eligible for Medicare	<b>Customer Service (24 hours):</b> 866.390.7772 <b>Nurseline:</b> 800.299.0274 <b>PPO Provider Finder:</b> <a href="http://bcbsil.com/providers">bcbsil.com/providers</a>	Claims Processing PO Box 1220 Chicago, IL 60690-1220
WageWorks (Retiree Medical Plan billing administrator)	<b>Customer Service:</b> 877.822.9091	PO Box 660212 Dallas, TX 75266-0212
Express Scripts — Prescription Plan	<b>Under Age 65 Customer Service:</b> 800.935.7189 <b>Age 65 and Over Customer Service:</b> 866.838.3979	PO Box 2858 Clinton, IA 52733-2858

## Take note

Faculty who retired under the Faculty Retirement Incentive Program, Early Retirement Option, do not pay premiums for themselves or dependents over age 65 enrolled in Medicare.

# Notices

If you and/or your dependent have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See the information below.

## Medicare Part D Creditable Coverage

Important Notice from the University of Chicago about Your Prescription Drug Coverage and Medicare. Please read this notice carefully and keep it where you can find it. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The University of Chicago has determined that the prescription drug coverage offered by your University of Chicago medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current University of Chicago prescription drug coverage will be affected.

- If you decide to KEEP your University of Chicago prescription drug coverage and enroll in a Medicare prescription drug plan, your University of Chicago coverage generally will be your primary coverage. You may be required to pay a Medicare Part D premium in addition to your University of Chicago medical plan contributions.
- If you do decide to join a Medicare drug plan and DROP your current University of Chicago prescription drug coverage—by dropping your medical plan, be aware that you and your dependents may not be able to get this coverage back.

## When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the University of Chicago and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

### **For More Information about This Notice or Your Current Prescription Drug Coverage**

Contact the Benefits Office at 855.822.8901 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the University of Chicago changes. You also may request a copy of this notice at any time.

### **For More Information about Your Options under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more Information about Medicare Prescription Drug Coverage:

- Visit [medicare.gov](https://www.medicare.gov).
- Call your state health insurance assistance program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1.800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

### **Newborns' and Mothers' Health Protection Act Notice**

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).

If you have questions or would like more information, please contact your medical plan provider. See page 40 for contact information.

### **Women's Health and Cancer Rights Act Notice**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. The amounts are shown on the chart on pages 16 - 17. If you have questions or would like more information, please contact your medical plan provider. See page 44 for contact information.

### **Health Insurance Portability And Accountability Act of 1996 (HIPAA)**

The University of Chicago takes the protection of your health information seriously. Federal law requires your health plans to provide a Notice of Privacy Practices, which describes how your health information is safeguarded, the circumstances in which your health information may be used, and your legal rights. For your convenience, you may request a copy by contacting the Benefits Office at 855.822.8901.

## HIPAA Notice of Special Enrollment Rights

THIS NOTICE DESCRIBES SPECIAL CIRCUMSTANCES WHICH MAY ALLOW YOU AND YOUR ELIGIBLE DEPENDENTS TO ENROLL IN GROUP HEALTH COVERAGE DURING THE YEAR. PLEASE REVIEW IT CAREFULLY.

The University of Chicago sponsors a group health plan (the “Plan”) to provide coverage for health care services for our employees and their eligible dependents. Our records show that you are eligible to participate, which requires that you complete enrollment in the Plan and pay your portion of the cost of coverage through payroll deductions, or decline coverage. A federal law called HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in the Plan under “special enrollment provisions” described below.

### Special Enrollment Provisions

**Loss of Other Coverage.** If you decline enrollment for yourself or for an eligible dependent because you had other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage or if the other employer stops contributing toward your or your dependents’ other coverage. You must request enrollment within 30 days after your or your dependents’ other coverage ends or after the other employer stops contributing toward the other coverage. Please contact the Benefits Office at 773.702.9634 for details, including the effective date of coverage added under this special enrollment provision.

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you gain a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents in the Plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered. Please contact the Benefits Office at 855.822.8901 for details, including the effective date of coverage added under this special enrollment provision.

### Enrollment Due to Medicaid/CHIP Events

If you or your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents in the Plan if: (i) you or your dependents lose coverage under a state Medicaid or Children’s Health Insurance Program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment **within 60 days** from the date of the Medicaid/CHIP event. Please contact the Benefits Office at 773.702.9634 for details, including the effective date of coverage added under this special enrollment provision).

### Contact Information

If you have any questions about this Notice or about how to enroll in the Plan, please contact the Benefits Office at 855.822.8901 or by writing to:

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

## Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [healthcare.gov](http://healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 1-877-KIDS NOW or [insurekidsnow.gov](http://insurekidsnow.gov) to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at [askebsa.dol.gov](http://askebsa.dol.gov) or call 1-866-444-EBSA (3272).

### Alabama - Medicaid

**Website:** <http://myalhipp.com/>  
**Phone:** 1-855-692-5447

### Alaska - Medicaid

#### The AK Health Insurance Premium Payment Program

**Website:** <http://myakhipp.com/>  
**Phone:** 1-866-251-4861

**Email:** [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)

**Medicaid Eligibility:**  
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

### Arkansas - Medicaid

**Website:** <http://myarhipp.com/>  
**Phone:** 1-855-MyARHIPP (855-692-7447)

### Colorado - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

**Health First Colorado Website:**  
<https://www.healthfirstcolorado.com/>

**Health First Colorado Member Contact Center:**  
 1-800-221-3943/ State Relay 711

**CHP+:** [Colorado.gov/HCPF/Child-Health-Plan-Plus](http://Colorado.gov/HCPF/Child-Health-Plan-Plus)

**CHP+ Customer Service:** 1-800-359-1991/  
 State Relay 711

### Florida - Medicaid

**Website:** <http://flmedicaidtplrecovery.com/hipp/>  
**Phone:** 1-877-357-3268

### Georgia - Medicaid

**Website:** <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>  
**Phone:** 1-678-564-1162 ext 2131

### Indiana - Medicaid

#### Healthy Indiana Plan for low-income adults 19-64

**Website:** <http://www.in.gov/fssa/hip/>  
**Phone:** 1-877-438-4479

#### All other Medicaid

**Website:** <http://www.indianamedicaid.com>  
**Phone:** 1-800-403-0864

### Iowa - Medicaid

**Website:** <http://dhs.iowa.gov/Hawki>  
**Phone:** 1-800-257-8563

### Kansas - Medicaid

**Website:** <http://www.kdheks.gov/hcf/>  
**Phone:** 1-785-296-3512

### Kentucky - Medicaid

**Website:** <https://chfs.ky.gov>  
**Phone:** 1-800-635-2570

**Louisiana - Medicaid****Website:**

<http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>

**Phone:** 1-888-695-2447

**Maine - Medicaid****Website:**

<http://www.maine.gov/dhhs/ofc/public-assistance/index.html>

**Phone:** 1-800-442-6003

**TTY:** Maine relay 711

**Massachusetts - Medicaid and CHIP****Website:**

<http://www.mass.gov/eohhs/gov/departments/masshealth/>

**Phone:** 1-800-862-4840

**Minnesota - Medicaid****Website:**

<https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

**Phone:** 1-800-657-3739

**Missouri - Medicaid****Website:**

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

**Phone:** 1-573-751-2005

**Montana - Medicaid****Website:**

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

**Phone:** 1-800-694-3084

**Nebraska - Medicaid**

**Website:** <http://www.ACCESSNebraska.ne.gov>

**Phone:** 1-855-632-7633

**Lincoln:** 1-402-473-7000

**Omaha:** 1-402-595-1178

**Nevada - Medicaid**

**Medicaid Website:** <https://dhcfp.nv.gov>

**Medicaid Phone:** 1-800-992-0900

**New Hampshire - Medicaid**

**Website:** <https://www.dhhs.nh.gov/oii/hipp.htm>

**Phone:** 1-603-271-5218

**Toll free number for the HIPP program:**

1-800-852-3345, ext 5218

**New Jersey - Medicaid and CHIP****Medicaid Website:**

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

**Medicaid Phone:** 1-609-631-2392

**CHIP Website:** <http://www.njfamilycare.org/index.html>

**CHIP Phone:** 1-800-701-0710

**New York - Medicaid**

**Website:** [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)

**Phone:** 1-800-541-2831

**North Carolina - Medicaid**

**Website:** <https://medicaid.ncdhhs.gov/>

**Phone:** 1-919-855-4100

**North Dakota - Medicaid**

**Website:** <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

**Phone:** 1-844-854-4825

**Oklahoma - Medicaid and CHIP**

**Website:** <http://www.insureoklahoma.org>

**Phone:** 1-888-365-3742

**Oregon - Medicaid**

**Website:** <http://healthcare.oregon.gov/Pages/index.aspx>

<http://www.oregonhealthcare.gov/index-es.html>

**Phone:** 1-800-699-9075

**Pennsylvania - Medicaid**

**Website:** <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>

**Phone:** 1-800-692-7462

**Rhode Island - Medicaid and CHIP**

**Website:** <http://www.eohhs.ri.gov/>

**Phone:** 1-855-697-4347 or 1-401-462-0311

(Direct RIte Share Line)

**South Carolina - Medicaid**

**Website:** <https://www.scdhhs.gov>

**Phone:** 1-888-549-0820

**South Dakota - Medicaid**

**Website:** <http://dss.sd.gov>

**Phone:** 1-888-828-0059

**Texas - Medicaid**

**Website:** <http://gethipptexas.com/>

**Phone:** 1-800-440-0493



**Utah - Medicaid and CHIP****Medicaid Website:** <https://medicaid.utah.gov/>**CHIP Website:** <http://health.utah.gov/chip>**Phone:** 1-877-543-7669**Vermont - Medicaid****Website:** <http://www.greenmountaincare.org/>**Phone:** 1-800-250-8427**Virginia - Medicaid and CHIP****Medicaid Website:**[http://www.coverva.org/programs\\_premium\\_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)**Medicaid Phone:** 1-800-432-5924**CHIP Website:** [http://www.coverva.org/programs\\_premium\\_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)**CHIP Phone:** 1-855-242-8282**Washington - Medicaid****Website:** <https://www.hca.wa.gov/>**Phone:** 1-800-562-3022 ext. 15473**West Virginia - Medicaid****Website:** <http://mywvhipp.com/>**Toll-free phone:** 1-855-MyWVHIPP (1-855-699-8447)**Wisconsin - Medicaid and CHIP****Website:**<https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>**Phone:** 1-800-362-3002**Wyoming - Medicaid****Website:** <https://wyequalitycare.acs-inc.com/>**Phone:** 1-307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[dol.gov/agencies/ebsa](http://dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and  
Human Services Centers for  
Medicare & Medicaid Services  
[cms.hhs.gov](http://cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2020)



*The University of Chicago does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, status as an individual with a disability, protected veteran status, genetic information, or other protected classes under the law. For additional information, please see [uchicago.edu/about/non\\_discrimination\\_statement](https://uchicago.edu/about/non_discrimination_statement).*

*This guide provides an overview of your University of Chicago Retiree Medical Plan. If there is a discrepancy between this guide and the plan document, the plan document will govern. In addition, the plan described in this guide is subject to change without notice. Continuation of benefits is at the University's discretion.*



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**Human  
Resources**