

2022

Retiree Medical Guide



THE UNIVERSITY OF
CHICAGO

Human
Resources

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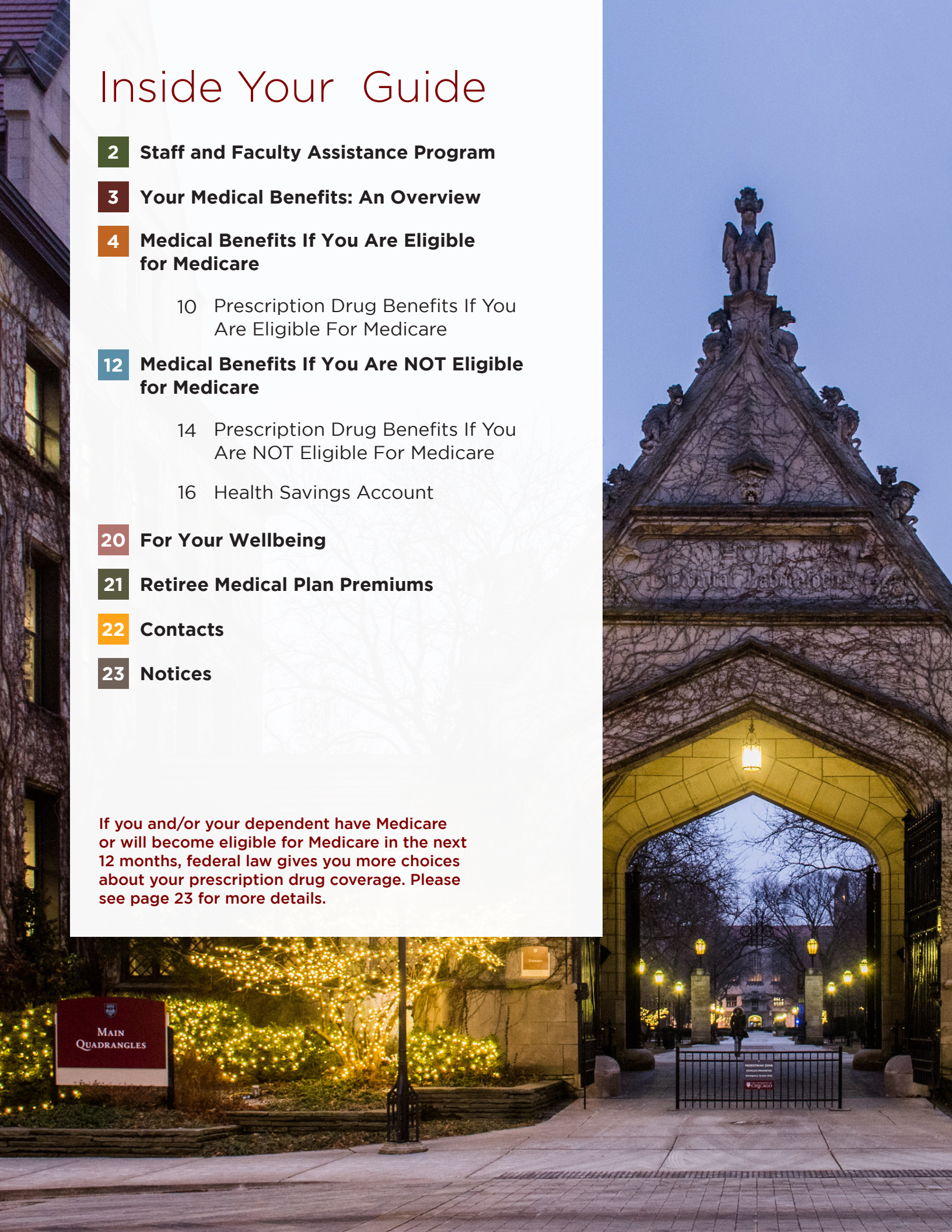
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If you and/or your dependent have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.



Dear Retiree Medical Plan Participant:

This Retiree Medical Guide provides you with information regarding your medical and prescription drug coverage **effective January 1, 2022**. 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®.
- If you are **not eligible for Medicare**, you have the choice of coverage in one of the four medical plans available to active employees.

New for 2022: Starting January 1, 2022, the University will now offer non-Medicare eligible retirees and their dependents a choice of coverage in one of the four medical plans available to active employees. This change will allow for the choice of plans with lower premiums and will give the ability to have consistency when transitioning from an active to a retired status.

Effective January 1, 2022, Aetna will be transitioning the Medicare Advantage plan to a new administrative platform. **All Medicare Advantage participants will receive new cards.** See page 8 for more details.

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.

Sincerely,

Elizabeth Walls

Elizabeth Walls

Executive 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 (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
Who is Eligible	<ul style="list-style-type: none"> • Retirees and their eligible dependents age 65 or older • Retirees and their eligible dependents who became disabled* before age 65 and are determined to be Medicare-eligible 	<ul style="list-style-type: none"> • Retirees and their eligible dependents younger than age 65 • Retirees living outside of the United States (Maroon Plans only)
Medical Plan	<ul style="list-style-type: none"> • Choice of two Retiree Medical Plans administered by Aetna® 	<ul style="list-style-type: none"> • Choice of enrollment in one of the University of Chicago medical plans available to active employees.
For More Information	<ul style="list-style-type: none"> • See page 4 	<ul style="list-style-type: none"> • See page 12

**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 one of the four medical plan options available to active employees.

Reminder: Bill Pay Administrator Name Change

The University of Chicago Retiree Bill Pay Administrator changed their name to WEX effective July 1, 2021. Bill Pay payments should be sent to WEX and not Discovery Benefits.

Each month, you will receive a premium invoice from WEX. You can also sign up for automatic payments by contacting WEX or by logging into your WEX online account.

If you have any questions, please contact WEX at 866.451.3399 or cobraadmin@wexhealth.com.

Medical Benefits If You Are Eligible for

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. If you would like to make changes to the plan that you selected, complete and return the enrollment form included in this package to the Benefits Office by November 30, 2021. If you are not making changes, you will remain on your current plan and do not need to complete the enrollment form. 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	
Overview of the plan	<ul style="list-style-type: none"> The Aetna Medicare Advantage Plan is a Medicare Part C plan that includes both Medicare Part A (hospital insurance) and Part B (medical insurance). Coverage under the Medicare Advantage Plan means you still have Medicare, but your insurance coverage is managed and paid for by Aetna.
How Aetna works with Medicare	<ul style="list-style-type: none"> Aetna, not Medicare, is the primary and only payer for your medical care; you are still part of the federal Medicare program. Your medical services must be provided by a doctor who accepts Medicare.
When you get care	<ul style="list-style-type: none"> Present your Aetna ID card; do not use your Medicare card (new Aetna ID cards will be issued for 2022). Retain your Medicare card in case you participate in hospital-based research studies or need to obtain hospice services.
Submitting claims and paying your provider	<ol style="list-style-type: none"> Pay your provider the applicable copay. Your provider will file your claim with Aetna. Aetna processes your claim in accordance with Medicare Part A and B benefits. You will receive an Explanation of Benefits (EOB) from Aetna. Pay your provider directly for the portion of the cost (if any) only after you have received both your EOB and your provider's bill. Providers may send bills right away, but you should wait for the next bill that comes after you have received your EOB. In some cases, providers will ask you to pay an applicable copay at the time of your visit.

Medicare

❗ Take note

Informed Health® Line

With the Informed Health® Line, you can speak to a registered nurse about health issues 24 hours a day, 7 days a week by calling 855.493.7019 for Medicare Advantage members, or 800.556.1555 for Supplemental Plan members.

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.

Plan Provision	Medicare Advantage Plan Aetna Medicare SM Plan (PPO) with Extended Service Area (ESA)	Medicare Supplement Plan Traditional Choice
Deductible per individual	\$150	\$300
Out-of-pocket maximum per individual*	\$1,000 (includes deductible, copays and coinsurance)	\$1,750 (includes deductible and coinsurance)
Office visits (Primary Care Physician/Specialist)	\$10/\$35 copay after the deductible	10% coinsurance after the deductible
Preventive care	100% covered	100% covered
Lab work	100% covered after the deductible	100% covered after the deductible
X-rays	\$35 copay after the deductible	10% coinsurance after the deductible
Durable medical equipment	10% coinsurance after the deductible	10% coinsurance after the deductible
Inpatient hospital	\$250 copay per admission after the deductible	\$250 copay, then 10% coinsurance after the deductible
Outpatient hospital	\$50 copay after the deductible	10% coinsurance after the deductible
Urgent care	\$65 copay	10% coinsurance
Emergency room	\$100 copay	10% after the deductible
Prior authorization	May be required	Not required
Additional benefits/coverage	SilverSneakers® fitness program Routine vision care Routine hearing services Hearing aid coverage Video doctor visits (telemedicine) Routine foot care Non-Emergency Transportation	Member discount program available that provides discounts on services such as vision services and hardware, fitness and hearing aids; see page 9

* Out-of-pocket maximum only applies to expenses covered by the plan.

Take note

Be sure to confirm that your providers accept Medicare 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® 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](https://www.aetna.com/retireeplans).** You can review the Step-by-Step Aetna *Provider Search Instructions* found on the Benefits website (see contacts on page 22).

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.

Medicare Part D Prescription Coverage

Your Medicare Part D prescription drug coverage will be administered by SilverScript. The Aetna Medicare Plans do not include Medicare Part D prescription drug coverage.

For information on your prescriptions or to find a SilverScript participating retail network pharmacy near you, visit [caremark.com](https://www.caremark.com). You can also call SilverScript at 833.958.2658. See page 10 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.

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 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 [AetnaRetireePlans.com](https://www.aetna.com/retireeplans).

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.

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 and are willing to bill Aetna.

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 22) and click on *Understanding Your Medicare Advantage Part C Explanation of Benefits (EOB)*.

New for 2022

Aetna is upgrading the system they use to administer the Medicare Advantage plan. That means some basic information, including your member ID number, will change. Because of this, Aetna will send you a new Aetna Medicare PPO ID card prior to January 1, 2022. **Keep an eye on your mail so you don't miss it.** It's important to show your new card to your providers any time you receive medical care in 2022. And remember to replace your current ID card with your new ID card on January 1, 2022.

Aetna is also upgrading their website. While your current log in credentials and the website address AetnaRetireePlans.com will remain the same, the website will now let you:

- Get a quick view of your plan – based on your personal preferences
- Connect to care – find tools and information to stay healthy such as wellness programs, discounts and resources to make life easier
- Gain secure access – to your digital ID card, coverage information, and personal tasks

Aetna Medicare Supplement Plan

How to Access Care

The Aetna Medicare Supplement Plan allows you to have more freedom regarding your healthcare. 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.

Explanation of Benefits (EOB)

The EOBs for the Medical Supplement plan will look different from the Medicare Advantage Plan:

- The Aetna EOB will show all claims for the month.
- The font on the Aetna EOB is smaller. This is because the University created a custom plan for our retirees and the EOBs are based on the non-Medicare system.

Keep in mind that you will receive an EOB from Aetna **after** Medicare processes your claim as primary.

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.

Additional Benefits

When you enroll in the Aetna Medicare Supplement Plan, you have access to the member discount program:

- **Vision** — Discounts on frames, lenses, eye exams and more
- **Hearing services** — Receive discounts on hearing aids, a free supply of batteries, and follow-up services on your hearing aid
- **Weight management** — Discounts on gym memberships, health coaching, in-home weight loss programs, healthy food options like meal delivery, fitness gear, and more

Once you are a member, go to [Aetna.com](https://www.aetna.com) for more information.

Prescription Drug Benefits If You Are Eligible For Medicare

Medicare Eligible Prescription Drug Benefits

You are automatically enrolled in the prescription drug program administered by SilverScript® Insurance Company, which is affiliated with CVS Caremark®. SilverScript has more than 65,000 participating network pharmacies nationwide for your retail prescription needs, plus convenient mail order/home delivery service.

Prescription Drug ID Cards

When you first enroll in Retiree Medical, you will receive a separate SilverScript 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.

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. SilverScript 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 (in-network)	Retail Pharmacy (30-day supply)	Home Delivery/ Mail Order Pharmacy (90-day supply)	Retail Pharmacy (90-day supply)
Generic Copay	You pay \$10	You pay \$20	You pay \$30
Preferred Brand Copay	You pay \$30	You pay \$60	You pay \$90
Non-Preferred Brand Copay	You pay \$50	You pay \$100	You pay \$150
Specialty Copay	You pay \$75	You pay \$150	You pay \$225

Where to fill your prescriptions

Retail Pharmacy	<p>Generally used to fill short-term prescriptions for temporary conditions. Short-term prescriptions are for a 30-day supply or less. Visit a participating retail pharmacy and present your ID card and prescription.</p> <p>To find a participating retail network pharmacy in your area, visit caremark.com.</p>
Home Delivery/ Mail Order Service	<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"> • Complete a home delivery order form and submit it along with a 90-day prescription from your doctor. Register as a member at caremark.com to print a copy of the form. • 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 member ID card.

Maintenance Drugs

If you take a maintenance medication, you can order your long-term medications through convenient mail-order service or purchase a 90-day supply at any of the 65,000 pharmacies in the network.

Note: You can fill a 31-day maintenance medication prescription twice at any retail pharmacy; then future fills must be completed through a 90-day supply.

If you are currently taking any long-term prescription drugs, you can continue to fill your 31-day supplies. However, you may save by changing your 31-day supply to a lower-cost 90-day supply. Filling one 90-day supply may cost you less than three 31-day supplies of the same prescription drug.



❗ 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.

Medical Benefits If You Are NOT Eligible

Medical

New for 2022: The University of Chicago will now offer Non-Medicare eligible Retirees the choice of coverage under one of the four medical insurance plans available to active employees, including two health maintenance organization (HMO) plans and two preferred provider organization plans (PPO):

- University of Chicago Health Plan (UCHP)
- Blue Cross Blue Shield HMO Illinois Plan (HMO Illinois)
- Blue Cross Blue Shield PPO Maroon Plan (Maroon PPO)
- Blue Cross Blue Shield HDHP Maroon Savings Choice Plan with Health Savings Account (Maroon Savings Choice)

Note: If you are living outside of the United States please elect one of the two Maroon plans only.

See [pages 18-19](#) for a chart that compares the key coverages for all four medical insurance plans.

HMO vs PPO: Which Plan Structure Is Right for You?

To help you decide which medical plan is right for you, first determine if you prefer the structure of an HMO or PPO.

Here's how an HMO works (UCHP & HMO Illinois):

- You must select a primary care physician (PCP) who manages your care using the HMO network's physicians and facilities.
- You will need approval from your PCP before seeing a specialist.
- There is no deductible to meet before the plan begins sharing in the cost of non-preventive care services.
- You pay a fixed copayment for each office visit, emergency room visit, and hospital stay.
- There are no claims to file.
- You must use doctors in your HMO's network unless it is a life-threatening emergency.

Here's how a PPO works (Maroon PPO & Maroon Savings Choice):

- You are not required to choose a primary care physician and do not need a referral to see a specialist.
- You must meet an annual deductible before the plan begins covering non-preventive care services.
- Once you have met your deductible, you and the plan share in the cost of covered health expenses through coinsurance.
- If you use in-network providers, there are no claims to file.

All four University of Chicago medical plans provide coverage for:

- Qualified in-network preventive care (no cost to you)
- Prescription drugs
- Emergency care anywhere in the world



For Medicare

If you prefer an HMO, keep in mind these key differences as you consider the two HMO options:

University of Chicago Health Plan (UCHP)	Blue Cross Blue Shield HMO Illinois (HMO Illinois)
<ul style="list-style-type: none"> All treatment covered is provided at University of Chicago Medicine facilities, including the University of Chicago Medical Center (UCMC), and by UCHP PCPs and UCHP Specialists. Services received at non-University of Chicago Medicine facilities or by non-UCHP-designated providers will not be covered unless it is an emergency. 	<ul style="list-style-type: none"> You have access to the Blue Cross Blue Shield HMO Illinois network of contracting doctors and hospitals to choose from when care is needed. Health care is provided within specific geographic areas called service areas. To be a member in HMO Illinois, you must live in its service area and you must use doctors in the network and within your service area unless it is an emergency.

If you prefer a PPO, keep in mind these important differences as you consider the two PPO options:

Blue Cross Blue Shield PPO Maroon Plan (Maroon PPO)	Blue Cross Blue Shield HDHP Maroon Savings Choice Plan (Maroon Savings Choice)
<ul style="list-style-type: none"> You will pay less out of pocket when you receive care at the University of Chicago Medical Center (UCMC). Your deductible and out-of-pocket maximum include in-network and out-of-network expenses combined. That means if you see an in-network doctor and pay \$200 for the service, and later see an out-of-network doctor and pay \$500 for the service, the combined amount of \$700 will apply to your deductible and out-of-pocket maximum. 	<ul style="list-style-type: none"> You have access to a Health Savings Account (HSA) and you can contribute pre-tax dollars. You are responsible for the full family deductible if you are enrolled with a spouse and/or children. You are responsible for the full cost of non-preventive prescription drugs until you have met your deductible. Once you have met the deductible, copayments will apply until you reach the out-of-pocket maximum.

You can review the Summary of Benefits and Coverage and glossary online at <https://humanresources.uchicago.edu/benefits/benefitplandocuments.shtml>, or you can request a paper copy, free of charge, through the Benefits Office at 773.702.9634 or retiree@uchicago.edu.



Prescription Drug Benefits If You Are NOT Eligible For Medicare

The Rx Factor: Prescription Drugs

Prescription drug coverage is provided automatically under your medical plan and is administered by either CVS Caremark or Prime Therapeutics, depending on which medical plan you choose.

If you enroll in	The prescription drug administrator is:
UCHP Maroon PPO Plan Maroon Savings Choice Plan	CVS Caremark
HMO Illinois	Prime Therapeutics

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

- **Generic drugs** are therapeutically equivalent to brand-name drugs in terms of safety, quality, performance, strength, dosage form and intended use, must be approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness, and cost less than brand-name drugs.
- **Preferred brand drugs** are safe, effective alternatives to non-preferred brands. The administrator 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 brand-name drugs that are not included on the administrator's list of preferred drugs, are typically more expensive than preferred brand drugs, and have recently come on the market.
- **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.

The cost for your prescription will depend on the type of drug (generic, preferred brand, non-preferred brand, or specialty), and whether the prescription is for 30 days (or 34 days for HMO Illinois) or 90 days. Using an in-network pharmacy will save you money. See the comparison chart on pages 18-19 for details on prescription coverage and copays for each medical plan.

Did you know?

The Duchossois Center for Advanced Medicine (DCAM) located at the University Medical Center and Ingalls outpatient pharmacies are considered in-network pharmacies for the CVS retail network.

What you need to know about prescription coverage

- Under the **UCHP, HMO Illinois, and Maroon PPO Plan**, prescriptions are not subject to the plan deductible.
- Under the **Maroon Savings Choice Plan**, non-preventive prescription costs are covered like any other expense, so you must meet the plan deductible before the plan pays benefits. However, **certain approved preventive prescriptions require only a copay and are not subject to the deductible.** Preventive prescription drugs help you manage chronic conditions, such as high cholesterol and high blood pressure, and they can help keep you from developing a health condition like heart disease or osteoporosis. You can view the list of approved preventive drugs at caremark.com.



Do you take a maintenance medication?

CVS Maintenance Choice Program

If you take a maintenance medication and are covered by the UCHP, Maroon PPO Plan, or Maroon Savings Choice Plan, you can order your long-term medications through convenient mail-order service or purchase a 90-day supply at any of the 65,000 pharmacies in the CVS network (including DCAM) at the same mail-order copay and discounts.

Keep in mind that you can fill a 30-day maintenance medication prescription twice at any retail pharmacy; then future fills must be completed through a 90-day supply. If you want to continue filling your maintenance medication as a 30-day supply, you can opt out of the Maintenance Choice Program by calling CVS Caremark at 866.873.8632.

Health Savings Account

The University of Chicago's Maroon Savings Choice Plan is a high-deductible medical plan that includes a Health Savings Account (HSA) to help you pay and/or save for health care expenses with tax-free dollars.

When you enroll in the Maroon Savings Choice Plan, the University will automatically open a Health Savings Account (HSA) for you with HSA Bank, a division of Webster Bank, an FDIC-insured institution. You can use this tax-advantaged account to pay for qualified health expenses, including medical, dental, and vision plan deductibles and coinsurance, office visits, and prescriptions.

The HSA offers several benefits:

- **Long-term savings opportunity:** Your balance rolls over from year to year with no "use it or lose it" rule, so you can build tax-free savings for future health care needs.
- **Money is portable:** You take your balance with you if you leave the University's plan – the money is always yours.

Your Contributions

You can make contributions to your HSA anytime throughout the 2022 calendar year via lump sum or reoccurring monthly contributions setup through your HSA vendor. Retirees making contributions on a post-tax basis can recoup the pre-tax benefits during your annual tax filing.

The IRS limits the amount that can be contributed to your HSA each year. For 2022, you can contribute:

If you are age 55 or older, you can contribute an additional \$1,000, regardless of your coverage level.

Contributions	Individual	Family
2022 IRS maximum	\$3,650	\$7,300



ⓘ Take note

If you are over age 65 and enrolled in Medicare Part A or B, you are not allowed to contribute to a Health Savings Account.

Triple-Tax Advantage

The HSA offers a triple-tax advantage — saving you money now and later:

1. Money you contribute to your account can be claimed tax-free during your annual tax filing
2. Money can grow tax-free with interest.
3. Money is withdrawn tax-free when used for qualified health expenses.

That means you will not pay taxes on these funds as long as you use them to pay for qualified health expenses.

How to pay with your HSA

Debit card.

When you enroll for the first time, you will receive a debit card within 10 business days of opening your account. You can use your debit card to pay for eligible expenses with money from your account.

Online.

Pay for eligible expenses out of your pocket, then go to hsabank.com to request reimbursement.

HSA checkbook.

You can pay by check. Go to hsabank.com or call 800.357.6246 to order a checkbook. A service fee will apply.

Eligibility

You are eligible to contribute to an HSA if you meet all of the following IRS requirements:

- You are covered by the Maroon Savings Choice Plan.
- You are not covered in any other Traditional Health Plan, Health Care Reimbursement Account (HRA), Health Care Flexible Spending Account (FSA), Tricare, and/or VA benefits.
- You are not claimed as a dependent on another person's tax return (excluding your spouse's).
- You are not enrolled in Medicare.
- You are not receiving Social Security benefits.

You are responsible for notifying HSA Bank if you are not eligible.

Transitioning from an FSA to HSA

If you have an FSA in 2021 and will open an HSA for 2022, make sure to use all the funds in your FSA by December 31, 2021. Using all your FSA funds by December 31, 2021 ensures you have the full year to contribute to your new HSA. You cannot open an HSA while still holding a balance in your FSA.

Protect your assets. Protect your loved ones.

You may designate a beneficiary to receive your HSA assets in the event of your death. A beneficiary can be one or more individuals such as your spouse, children, other relatives, or friends, or organizations such as a trust or charity. To designate a beneficiary or update your current beneficiary with HSA Bank, log on to HSA Bank at <https://myaccounts.hsabank.com/Login.aspx?ReturnUrl=%2F>:

- Once you are logged into your account, click on the Profile tab.
- Then click on "Add Beneficiary."
- You will be asked to provide information about your beneficiary, including his/her Social Security Number and his/her birth date. Once you complete the form, click "Submit."

Compare the Plans

Here is a side-by-side comparison of the key elements under each medical plan.

	University of Chicago Health Plan (UCHP)	Blue Cross Blue Shield HMO Illinois Plan (HMO Illinois)
Deductible (Individual/Family)	None	None
Out-of-pocket maximum (Individual/Family)	\$1,500/\$3,000	\$1,500/\$3,000
Physician office visits (non-preventive)	\$25 copayment for PCP ¹ visit, \$45 copayment for specialist visit	\$25 copayment for PCP ¹ visit, \$45 copayment for specialist visit
Maternity	You pay nothing or a minimal copayment, then Plan pays 100%	You pay nothing or a minimal copayment, then Plan pays 100%
Knee/hip replacement	You pay nothing or a minimal copayment, then Plan pays 100%	You pay nothing or a minimal copayment, then Plan pays 100%
Hospital inpatient	\$350 copayment per admission	\$350 copayment per admission
Hospital outpatient	100% covered	100% covered
Emergency room	\$125 copayment; waived if admitted	\$125 copayment; waived if admitted
Ongoing therapy, occupational and physical therapy	Limit of 60 combined treatments per calendar year	Limit of 60 combined treatments per calendar year; \$25 copayment per visit
Mental health outpatient	\$25 copayment per visit	\$25 copayment per visit
Hearing Exam Hearing Aids	100% covered; One hearing aid per ear covered up to \$2,500 every 24 months (covered at 100% if you are under 18)	\$25 PCP ¹ /\$45 specialist; One hearing aid per ear covered up to \$2,500 every 24 months (covered at 100% if you are under 18)
Prescription drugs (Generic/Preferred brand/Non-preferred brand/Specialty ⁵)	<ul style="list-style-type: none"> Retail (30-day supply): \$10/\$30/\$50/\$75 copayment; 50% copayment for maintenance medications after second refill (not applicable if filled by DCAM4 Pharmacy) Retail at DCAM4 and Ingalls⁵ pharmacies: \$5/\$15/\$30/\$75 copayment Mail service at DCAM4 and Ingalls⁵ pharmacies (90-day supply): \$10/\$30/\$60 copayment Mail service (90-day supply) with CVS Caremark: \$20/\$60/\$100 copayment Administered by CVS Caremark	<ul style="list-style-type: none"> Retail (34-day supply): \$10/\$30/\$50/\$75 copayment Mail service (90-day supply): \$20/\$60/\$100 copayment \$50 copayment for self-injectables Administered by Prime Therapeutics

¹PCP = Primary care physician.

²You are also responsible for 100% of the charges in excess of the prevailing fee schedule.

³100% applies to the surgery only; doctor visits subject to applicable coinsurance.

⁴DCAM = Duchossois Center for Advanced Medicine at the University of Chicago Medicine.

⁵Specialty prescription drugs are only available through CVS Specialty for up to a 30-day supply.

Blue Cross Blue Shield PPO Maroon Plan (Maroon PPO)			Blue Cross Blue Shield HDHP Maroon Savings Choice Plan (Maroon Savings Choice)	
University of Chicago Medical Center (UCMC)	In-network	Out-of-network	In-network	Out-of-network
\$300/\$600	\$500/\$1,000	\$500/\$1,000 (additional \$200 per hospital admission)	\$2,000/\$4,000	\$4,000/\$8,000 (additional \$200 per hospital admission)
\$1,750/\$3,500	\$2,500/\$5,000 (combined in- and out-of-network)		\$3,000/\$6,000	\$6,000/\$12,000
You pay 10%	You pay 20%	You pay 35% ²	You pay 20%	You pay 35% ²
100% after deductible ³	You pay 20%	You pay 35% ²	You pay 20%	You pay 35% ²
100% after deductible ³	You pay 20%	You pay 35% ²	You pay 20%	You pay 35% ²
You pay 10%	You pay 20%	You pay 35% ² (after \$200 deductible)	You pay 20%	You pay 35% ² (after \$200 deductible)
You pay 10%	You pay 20%	You pay 35% ²	You pay 20%	You pay 35% ²
You pay 10%	You pay 20%	You pay 20%	You pay 20%	You pay 20%
Limit of 60 combined treatments per calendar year, after the deductible			Limit of 60 combined treatments per calendar year, after the deductible	
You pay 10%	You pay 20%	You pay 35% ²	You pay 20%	You pay 35% ²
Not covered; After deductible - one hearing aid per ear covered up to \$2,500 every 24 months (covered at 100% if you are under 18)			Not covered; After deductible - one hearing aid per ear covered up to \$2,500 every 24 months (covered at 100% if you are under 18)	
<ul style="list-style-type: none"> Retail (30-day supply): \$10/\$30/\$50 copayment Specialty Retail (30-day supply): 30% coinsurance; \$0 copay if you enroll in the copay coupon program through CVS Caremark Mail Service (90-day supply): \$20/\$60/\$100 copayment Separate out-of-pocket maximum for Rx: \$2,000 individual/\$4,000 family Administered by CVS Caremark			<ul style="list-style-type: none"> Retail (30-day supply): \$10/\$30/\$50/\$75 copayment after deductible Mail service (90-day supply): \$20/\$60/\$100 copayment after deductible You are responsible for the full cost of non-preventive drugs until the plan deductible has been met, thereafter the copayments apply Administered by CVS Caremark	

¹PCP = Primary care physician.²You are also responsible for 100% of the charges in excess of the prevailing fee schedule.³100% applies to the surgery only; doctor visits subject to applicable coinsurance.⁴DCAM = Duchossois Center for Advanced Medicine at the University of Chicago Medicine.⁵Specialty prescription drugs are only available through CVS Specialty for up to a 30-day supply.

For Your Wellbeing

Your overall wellbeing is important to you, your family, and the University. These **no-cost** virtual programs help you receive the support you need, when and where you need it. You and your dependents' eligibility for each program is dependent on the medical plan you are enrolled in; the eligible medical plans for each program are noted below.

Well onTarget

HMO Illinois, Maroon PPO, Maroon Savings Choice

Well onTarget is your 24/7 virtual resource for the support you need to make healthy choices. Well onTarget gives you access to a secure website with personalized tools and resources, including health and wellness content, a health assessment, interactive tools, and medical and lifestyle trackers to help you stay on course. Well onTarget also offers coaching programs with health experts to help you with quitting tobacco, improving your fitness level or dietary habits, and more. And as you are getting healthy, you'll earn Blue PointsSM rewards to redeem in the online Shopping Mall.

To get started or learn more, register on the Well onTarget Portal at www.wellontarget.com or download the Well onTarget mobile app and click "New User Registration."

Hinge Health

Maroon PPO, Maroon Savings Choice

Don't let chronic back and joint pain hold you back. Hinge Health can help you conquer your pain without drugs or surgery. Hinge Health is a 12-week coach-led program designed to reduce your back and joint pain through personalized exercise therapy, interactive education and tools, and unlimited 1-on-1 health coaching. Hinge Health provides a free tablet computer and wearable sensors to track your body's movement and guide you through exercises proven to reduce pain. Hinge Health is a completely digital program so you can access it when and where you need it, and the exercise sessions can be done in as little as 45 minutes per week.

To get started or learn more, go to www.hingehealth.com/uchicago or call 855.902.2777.

Livongo Health

Maroon PPO, Maroon Savings Choice

Livongo provides you with a better way to manage diabetes and high blood pressure. This free program combines the latest technology and expert coaching from clinical personnel to help you manage your condition. When you enroll in diabetes management, you will receive a free Bluetooth-enabled glucose meter — with unlimited test strips — and lancets.

When you enroll in high blood pressure management, you will receive a blood pressure monitor. To get started or learn more, go online to www.get.livongo.com/UNIVERSITYOFCHICAGO.

Wondr Health

HMO Illinois, Maroon PPO, Maroon Savings Choice

Wondr Health is an easy, online weight loss program that teaches clinically-proven healthy habits to reduce stress, increase energy and achieve healthy weight loss. You will learn when and how you eat. Wondr Health teaches you skills to help you lose weight and keep it off, while eating the foods you love. Available for you and your covered dependents over age 18 with a BMI of 25 or greater, the personalized program provides interactions with health coaches and an online community. To get started or learn more, go to www.wondrhealth.com/UChicago.

Well onTarget Fitness Program

Join the Well onTarget Fitness Program and pay a monthly fee per person for access

to one of over 10,000 fitness locations nationwide. You can go when you want and switch as often as you like. Find out more by logging in to BlueAccess for Members at <https://members.hcsc.net/wps/portal/bam>.

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.

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

Monthly Premiums Effective January 1, 2022

Medicare Eligible — Table A

Coverage Level	Medicare Advantage	Medicare Supplement
One person age 65 or older	\$232	\$342
Two people age 65 or older	\$464	\$684

Non-Medicare Eligible — Table B

Coverage Level	Maroon PPO	Maroon Savings	UCHP	BCBS HMO
One person under age 65	\$704	\$610	\$551	\$392
Two people under age 65	\$1,407	\$1,220	\$1,102	\$785
Three people under age 65	\$2,111	\$1,829	\$1,653	\$1,177

Note: If you are age 65 or older and covering a dependent who is under age 65, add the amount from Table B to the applicable rate from Table A. Similarly, if you are under age 65 and are covering a dependent who is age 65 or older, add the amount from Table A to the applicable rate from Table B.

Contacts

Contact Information		Address
University of Chicago Human Resources Benefits Office	Phone: 855.822.8901 Fax: 773.834.0996 Email: retiree@uchicago.edu Website: https://humanresources.uchicago.edu/benefits/	6054 S. Drexel Ave. Chicago, IL 60637
WEX - Retiree Medical Plan Billing Administrator	Customer Service: 866.451.3399 cobraadmin@wex.com cobralogin.wexhealth.com	PO Box 2079 Omaha, NE 68103-2079
Medicare Eligible Retirees		
Aetna - Medicare Advantage Plan	Member Services (8 a.m. - 6 p.m.): 888.267.2637 aetnaretireeplans.com	PO Box 981106 El Paso, TX 79998-1106
Aetna - Medicare Supplement Plan	Member Services (24 hours): 800.238.6716 aetna.com	PO Box 981106 El Paso, TX 79998-1106
SilverScript — Prescription Plan	Member Services: 833.958.2658	P.O. Box 52066 Phoenix, AZ 85072-2066
Non-Medicare Eligible Retirees		
Blue Cross Blue Shield of Illinois - Maroon Savings, Maroon PPO and HMO Plans	Member Services: Maroon Plans: 866.390.7772 HMO Plan: 800.892.2803 bcbsil.com	
HSA Bank - Maroon Savings Plan Health Savings Account Vendor	Member Services: 800.357.6246 hsabank.com	
Aetna - University of Chicago Health Plan (UCHP)	Member Services: 855.824.3632 uchp.uchicago.edu	
CVS Caremark (Pharmacy) — UCHP, Maroon Savings and Maroon PPO Plans	Member Services: 866.873.8632 caremark.com	
Prime Therapeutics (Pharmacy) — Blue Cross Blue Shield of Illinois HMO Plan	Member Services: 800.423.1973 bcbsil.com	

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 773.702.9634 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.

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

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 773.702.9634.

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 773.702.9634 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 773.702.9634 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 www.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 www.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 www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility -

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

ARKANSAS - Medicaid

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

CALIFORNIA - Medicaid

Health Insurance Premium Payment (HIPP) Program Website: <http://dhcs.ca.gov/hipp>
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

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+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA - Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 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: <https://www.in.gov/medicaid/>
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
 Medicaid Phone: 1-800-338-8366
 Hawki Website: <http://dhs.iowa.gov/Hawki>
 Hawki Phone: 1-800-257-8563
 HIPP Website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
 HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
 Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
 Phone: 1-855-459-6328
 Email: KIHIPPPROGRAM@ky.gov
 KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
 KCHIP Phone: 1-877-524-4718
 Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
 Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: <https://www.maine.gov/dhhs/ofi/applications-forms>
 Phone: 1-800-442-6003; TTY: Maine relay 711
 Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>
 Phone: 1-800-977-6740; 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/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> [Under ELIGIBILITY tab, see “what if I have other health insurance?”]
 Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: 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: 402-473-7000
 Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>
 Phone: 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: 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/
 Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 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 and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 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

Website: <https://www.coverva.org/hipp/>
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

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: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

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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.

