Inside Your Guide

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, 2024. 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 2024: Starting January 1, 2024 we will make the following changes to the plans:

- Medicare Advantage Plan
  - You will see a 9.4% increase in your premiums:
    - The primary drivers of premium increases are rising costs due to medical inflation and claims utilization.
    - In addition, Medicare plans expect to receive less revenue for the Centers for Medicare and Medicaid Services (CMS) in 2024 due to some legislative changes.
  - You will receive a new medical ID card prior to the end of December. Your member number will not change, and you can continue using your current card until the new card arrives.

- Medicare Supplement Plan
  - You will see a 3.1% increase in your premiums due to claims utilization.

- Non-Medicare Plans
  - Premiums are detailed on the Retiree Medical Plan Premiums page.

NOTE: You and your dependents may be eligible for different medical plans based on each individual’s Medicare eligibility. The family member who is Medicare-eligible will be covered by one of the Aetna plans. The family member who is non-Medicare eligible will be covered by one of the non-Medicare medical plans.

See page 6 of your guide for more coverage 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
Executive Director of Health, Welfare, and Retirement
Human Resources

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)
Retirement Information

Retiree Medical Insurance
The Retiree Medical Plan is available to employees who retire from the University and 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.

If you are Eligible for Medicare...
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. In order to be enrolled in one of the Aetna plans, you must be enrolled in Medicare parts A and B. There is a cost to Medicare that you must pay in addition to the premiums for the Aetna plan you elect. For information or to enroll, contact Medicare at 800.633.4227 or visit www.Medicare.gov.

If you are not Eligible for Medicare...
The University offers non-Medicare eligible retirees a choice of enrollment in one of the University of Chicago medical plans available to active employees.

Enrollment
If eligible, please request the Retiree Medical Plan Enrollment Form from the Benefits Office at retiree@uchicago.edu or 855.822.8901.

Postponement
You have the option of postponing enrollment in the Retiree Medical Plan until a later date as long as you meet the eligibility requirements on your termination date. If eligible, please request the Retiree Medical Plan Election to Postpone Form from the Benefits Office at retiree@uchicago.edu or 855.822.8901. Completed forms must be returned to the Benefits Office within 30 days from your termination date.

Retirement Meeting
Up to 60 days before your planned retirement date, contact the Benefits Office to schedule an appointment with a Benefits Specialist. They can assist you in completing the appropriate paperwork, provide you details on your Pension benefits, and review your retiree medical coverage options.

Keeping Contact & Personal Information Updated
As a Retiree, it is important to keep your contact information (address, home phone and email) up to date with the University. The University needs to be able to contact you about account updates for the pension, retirement plans, and the Retiree Medical Plan. If your or your beneficiary’s contact information changes, please send an email to the Benefits Office: retiree@uchicago.edu. You should also send any updates to personal or beneficiary information.
Your Medical Benefits: An Overview

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

<table>
<thead>
<tr>
<th>Who is Eligible</th>
<th>Eligible for Medicare</th>
<th>Not Eligible for Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Retirees and their eligible dependents age 65 or older</td>
<td>• Retirees and their eligible dependents age 65 or older</td>
<td>• Retirees and their eligible dependents younger than age 65</td>
</tr>
<tr>
<td>• Retirees and their eligible dependents who became disabled* before age 65 and are determined to be Medicare-eligible</td>
<td></td>
<td>• Retirees living outside of the United States (Maroon Plans only)</td>
</tr>
</tbody>
</table>

Medical Plan
- Choice of two Retiree Medical Plans administered by Aetna®
- Choice of enrollment in one of the University of Chicago medical plans available to active employees.

For More Information
- See page 4
- 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
The University of Chicago Retiree Bill Pay Administrator is WEX.

Each month, you will receive a premium invoice from WEX. Bill Pay payments should be sent to 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 send an email to cobraadmin@wexhealth.com.
Medical Benefits If You Are Eligible for Medicare

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.

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:

<table>
<thead>
<tr>
<th>Aetna Medicare Advantage Plan</th>
<th>Medicare Supplement Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview of the plan</strong></td>
<td></td>
</tr>
<tr>
<td>• The Aetna Medicare Advantage Plan is a Medicare Part C plan that includes both Medicare Part A (hospital insurance) and Part B (medical insurance).</td>
<td>• Coverage under the Medicare Advantage Plan means you still have Medicare, but your insurance coverage is managed and paid for by Aetna.</td>
</tr>
<tr>
<td>• Coverage under the Medicare Advantage Plan means you still have Medicare, but your insurance coverage is managed and paid for by Aetna.</td>
<td>• The Medicare Supplement Plan coordinates payments with Medicare Part A and B and supplements the Medicare coverage by paying additional amounts not covered.</td>
</tr>
<tr>
<td><strong>How Aetna works with Medicare</strong></td>
<td></td>
</tr>
<tr>
<td>• Aetna, not Medicare, is the primary and only payer for your medical care; you are still part of the federal Medicare program.</td>
<td>• Medicare provides your primary medical coverage and pays first.</td>
</tr>
<tr>
<td>• Your medical services must be provided by a doctor who accepts Medicare.</td>
<td>• The Aetna Medicare Supplement Plan will process second and pay additional amounts not covered by Medicare.</td>
</tr>
<tr>
<td><strong>When you get care</strong></td>
<td></td>
</tr>
<tr>
<td>• Present your Aetna ID card; do not use your Medicare card.</td>
<td>• Present your red, white, and blue Medicare ID card.</td>
</tr>
<tr>
<td>• Retain your Medicare card in case you participate in hospital-based research studies or need to obtain hospice services.</td>
<td>• Present your red, white, and blue Medicare ID card and Aetna ID card.</td>
</tr>
<tr>
<td><strong>Submitting claims and paying your provider</strong></td>
<td></td>
</tr>
<tr>
<td>1. Pay your provider the applicable copay.</td>
<td>1. Your provider will file your claim with Medicare.</td>
</tr>
<tr>
<td>2. Your provider will file your claim with Aetna.</td>
<td>2. Your provider will file your claim with Aetna.</td>
</tr>
<tr>
<td>3. Aetna processes your claim in accordance with Medicare Part A and B benefits.</td>
<td>3. Aetna processes your claim in accordance with Medicare Part A and B benefits.</td>
</tr>
<tr>
<td>4. You will receive an Explanation of Benefits (EOB) from Aetna.</td>
<td>4. You will receive an Explanation of Benefits (EOB) from Aetna.</td>
</tr>
<tr>
<td>5. 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.</td>
<td>5. 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.</td>
</tr>
</tbody>
</table>
Medical Benefits If You Are Eligible for 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 Supplement members.

Aetna Medicare Advantage Plan
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.

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.

How Aetna works with Medicare
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.

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.

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Medicare Advantage Plan Aetna MedicareSM Plan (PPO) with Extended Service Area (ESA)</th>
<th>Medicare Supplement Plan Traditional Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per individual</strong></td>
<td>$150</td>
<td>$300</td>
</tr>
<tr>
<td>Out-of-pocket maximum per individual*</td>
<td>$1,000</td>
<td>$1,750</td>
</tr>
<tr>
<td>(includes deductible, copays and coinsurance)</td>
<td></td>
<td>(includes deductible and coinsurance)</td>
</tr>
<tr>
<td>Office visits (Primary Care Physician/Specialist)</td>
<td>$10/$30 copay after the deductible</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Preventive care</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Lab work</td>
<td>100% covered after the deductible</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>X-rays</td>
<td>$30 copay after the deductible</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance after the deductible</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>$250 copay per admission after the deductible</td>
<td>$250 copay, then 10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>$50 copay after the deductible</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Services (Speech/physical/occupational therapy)</td>
<td>$30 copay</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$65 copay</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$100 copay</td>
<td>10% coinsurance after the deductible</td>
</tr>
<tr>
<td>Prior authorization</td>
<td>May be required</td>
<td>Not required</td>
</tr>
<tr>
<td>Routine dental care</td>
<td>$0 deductible $750 annual benefit maximum Preventive dental services including basic cleanings, checkups and X-rays</td>
<td>Not included</td>
</tr>
<tr>
<td>Vision services</td>
<td>Routine Eye Exams: $0; 1 every 12 months Diabetic Eye Exams: $0 Medicare Covered Eye Exam: $30</td>
<td>Routine Eye Exam: 100% covered 1 routine eye exam per 12 months</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Reimbursable up to $2,000 every 24 months</td>
<td>10% coinsurance after the deductible up to $2,000 every 24 months</td>
</tr>
<tr>
<td>Additional benefits/coverage</td>
<td>SilverSneakers® fitness program Routine hearing services Routine foot care Video doctor visits (telemedicine) Non-Emergency Transportation</td>
<td>Routine hearing services Member discount program available that provides discounts on services such as vision services and hardware, fitness and hearing aids; see page 9</td>
</tr>
</tbody>
</table>

*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.** 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. 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.

**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.
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).

Preventive Dental Benefits

Preventive visits to the dentist are important to your overall health. Medicare Advantage members have access to a preventive dental plan to help assist with your oral care expenses. Coverage includes:

<table>
<thead>
<tr>
<th>Aetna Preventive Dental Value ESA Plan</th>
<th>In-Network</th>
<th>Out-of-Network (80% Usual &amp; Customary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (cleanings), routine exams, bitewing and full mouth series x-rays, space maintainers</td>
<td>100% covered up to the annual max</td>
<td>100% covered up to the annual max</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Annual Maximum (Aetna pays)</td>
<td>$750</td>
<td></td>
</tr>
<tr>
<td>Waiting Period</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Preventive Dental Benefits Frequently Asked Questions:

Is there a deductible?
No, you have a $0 dental deductible for covered preventive dental services.

What is the member’s coinsurance?
You pay 0% coinsurance for each covered preventive dental service.

How many cleanings are included?
Your plan includes two cleanings (prophylaxis) per calendar year.

Is there an annual benefit maximum?
Yes. Aetna pays up to $750 each year for the non-Medicare covered preventive dental services included in the plan.

What other preventive services are included?
Oral exams and x-rays are also included; please refer to the member Schedule of Cost Sharing (SOC) for covered services and frequency limitations.
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

Hearing services – receive discounts on hearing aids, a free supply of batteries, and follow-up services on your hearing aid. There are two providers to choose from to obtain hearing service discounts. See below or visit Aetna’s secure member website for more details.

1. Hearing Care Solutions: 866.344.7756
2. Amplifon Hearing Health Care: 877.301.0840

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
- 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 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.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Retail Pharmacy (30-day supply)</th>
<th>Home Delivery/ Mail Order Pharmacy (90-day supply)</th>
<th>Retail Pharmacy (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Copay</td>
<td>You pay $10</td>
<td>You pay $20</td>
<td>You pay $30</td>
</tr>
<tr>
<td>Preferred Brand Copay</td>
<td>You pay $30</td>
<td>You pay $60</td>
<td>You pay $90</td>
</tr>
<tr>
<td>Non-Preferred Brand Copay</td>
<td>You pay $50</td>
<td>You pay $100</td>
<td>You pay $150</td>
</tr>
<tr>
<td>Specialty Copay</td>
<td>You pay $75</td>
<td>You pay $150</td>
<td>You pay $225</td>
</tr>
</tbody>
</table>
**Where to fill your prescriptions**

| Retail Pharmacy | 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. To find a participating retail network pharmacy in your area, visit caremark.com. |
| Home Delivery/ Mail Order Service | 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:  
  • 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.
The University of Chicago offers 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:

<table>
<thead>
<tr>
<th>University of Chicago Health Plan (UCHP)</th>
<th>Blue Cross Blue Shield HMO Illinois (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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.</td>
<td>• You have access to the Blue Cross Blue Shield HMO Illinois network of contracting doctors and hospitals to choose from when care is needed.</td>
</tr>
<tr>
<td>• Services received at non-University of Chicago Medicine facilities or by non-UCHP-designated providers will not be covered unless it is an emergency.</td>
<td>• 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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Blue Cross Blue Shield PPO Maroon Plan (Maroon PPO)</th>
<th>Blue Cross Blue Shield HDHP Maroon Savings Choice Plan (Maroon Savings Choice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You will pay less out of pocket when you receive care at the University of Chicago Medical Center (UCMC).</td>
<td>• You have access to a Health Savings Account (HSA) and you can contribute pre-tax dollars.</td>
</tr>
<tr>
<td>• 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.</td>
<td>• You are responsible for the full family deductible if you are enrolled with a spouse and/or children.</td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>If you enroll in</th>
<th>The prescription drug administrator is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCHP Maroon PPO Plan</td>
<td>CVS Caremark</td>
</tr>
<tr>
<td>Maroon Savings Choice Plan</td>
<td></td>
</tr>
<tr>
<td>HMO Illinois</td>
<td>Prime Therapeutics</td>
</tr>
</tbody>
</table>

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 2024 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 2024, you can contribute:

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>2024 IRS maximum</td>
<td>$4,150</td>
<td>$8,300</td>
</tr>
</tbody>
</table>

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

**Take note**

If you are disabled or over age 65 and enrolled in any part of Medicare, 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**

<table>
<thead>
<tr>
<th>Debit card.</th>
<th>Online.</th>
<th>HSA checkbook.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Pay for eligible expenses out of your pocket, then go to hsabank.com to request reimbursement.</td>
<td>You can pay by check. Go to hsabank.com or call 800.357.6246 to order a checkbook. A service fee will apply.</td>
</tr>
</tbody>
</table>

**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 2023 and will open an HSA for 2024, make sure to use all the funds in your FSA by December 31, 2023. Using all your FSA funds by December 31, 2023 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 hsabank.com:

- 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.

<table>
<thead>
<tr>
<th>Element</th>
<th>University of Chicago Health Plan (UCHP)</th>
<th>Blue Cross Blue Shield HMO Illinois Plan (HMO Illinois)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Individual/Family)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Out-of-pocket maximum (Individual/Family)</td>
<td>$1,500/$3,000</td>
<td>$1,500/$3,000</td>
</tr>
<tr>
<td>Physician office visits (non-preventive)</td>
<td>$25 copayment for PCP(^1) visit, $45 copayment for specialist visit</td>
<td>$25 copayment for PCP(^1) visit, $45 copayment for specialist visit</td>
</tr>
<tr>
<td>Maternity</td>
<td>You pay nothing or a minimal copayment, then Plan pays 100%</td>
<td>You pay nothing or a minimal copayment, then Plan pays 100%</td>
</tr>
<tr>
<td>Knee/hip replacement</td>
<td>You pay nothing or a minimal copayment, then Plan pays 100%</td>
<td>You pay nothing or a minimal copayment, then Plan pays 100%</td>
</tr>
<tr>
<td>Hospital inpatient</td>
<td>$350 copayment per admission</td>
<td>$350 copayment per admission</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$125 copayment; waived if admitted</td>
<td>$125 copayment; waived if admitted</td>
</tr>
<tr>
<td>Ongoing therapy, occupational and physical therapy</td>
<td>Limit of 60 combined treatments per calendar year</td>
<td>Limit of 60 combined treatments per calendar year; $25 copayment per visit</td>
</tr>
<tr>
<td>Mental health outpatient</td>
<td>$25 copayment per visit</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td>100% covered; One hearing aid per ear covered up to $2,500 every 24 months (covered at 100% if you are under 18)</td>
<td>$25 PCP/$45 specialist; One hearing aid per ear covered up to $2,500 every 24 months (covered at 100% if you are under 18)</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription drugs (Generic/Preferred brand/Non-preferred brand/Specialty(^5))</td>
<td>• Retail (30-day supply): $10/$30/$50 copayment; 50% copayment for maintenance medications after second refill (not applicable if filled by DCAM(^4) pharmacy)</td>
<td>• Retail (34-day supply): $10/$30/$50/$75 copayment</td>
</tr>
<tr>
<td></td>
<td>• Retail at DCAM(^4) and Ingalls(^5) pharmacies (30-day supply): $5/$15/$30 copayment</td>
<td>• Mail service (90-day supply): $20/$60/$100 copayment</td>
</tr>
<tr>
<td></td>
<td>• Specialty Retail at CVS and DCAM(^4) pharmacies only (30-day supply): 30% coinsurance; $0 copay if you enroll in the copay coupon program through CVS Caremark</td>
<td>• $50 copayment for self-injectables</td>
</tr>
<tr>
<td></td>
<td>• Mail service at DCAM(^4) and Ingalls(^5) pharmacies (90-day supply): $10/$30/$60 copayment</td>
<td>Administered by Prime Therapeutics</td>
</tr>
<tr>
<td></td>
<td>• Mail service with CVS Caremark (90-day supply): $20/$60/$100 copayment</td>
<td></td>
</tr>
</tbody>
</table>

1\(\text{PCP} = \) Primary care physician.
2\(\text{You are also responsible for 100\% of the charges in excess of the prevailing fee schedule.}\)
3\(100\% \text{ applies to the surgery only; doctor visits subject to applicable coinsurance.}\)
4\(\text{DCAM = Duchossois Center for Advanced Medicine at the University of Chicago Medicine.}\)
5\(\text{Specialty prescription drugs are only available through CVS Specialty for up to a 30-day supply.}\)
### Blue Cross Blue Shield PPO Maroon Plan (Maroon PPO)

<table>
<thead>
<tr>
<th>University of Chicago Medical Center (UCMC)</th>
<th>In-network</th>
<th>Out-of-network</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300/$600</td>
<td>$500/$1,000</td>
<td>$500/$1,000 (additional $200 per hospital admission)</td>
<td>$2,000/$4,000</td>
<td>$4,000/$8,000 (additional $200 per hospital admission)</td>
</tr>
<tr>
<td>$1,750/$3,500</td>
<td>$2,500/$5,000 (combined in- and out-of-network)</td>
<td>$3,000/$6,000</td>
<td>$6,000/$12,000</td>
<td></td>
</tr>
</tbody>
</table>

- You pay 10%
- You pay 20%
- You pay 35%
- You pay 20%
- You pay 35%
- You pay 20%
- You pay 10%
- You pay 20%
- You pay 35%
- You pay 20%
- You pay 35%
- You pay 20%

Limit of 60 combined treatments per calendar year, after the deductible

- 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)

- 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

### Blue Cross Blue Shield HDHP Maroon Savings Choice Plan (Maroon Savings Choice)

<table>
<thead>
<tr>
<th>University of Chicago Medical Center (UCMC)</th>
<th>In-network</th>
<th>Out-of-network</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300/$600</td>
<td>$500/$1,000</td>
<td>$500/$1,000 (additional $200 per hospital admission)</td>
<td>$2,000/$4,000</td>
<td>$4,000/$8,000 (additional $200 per hospital admission)</td>
</tr>
<tr>
<td>$1,750/$3,500</td>
<td>$2,500/$5,000 (combined in- and out-of-network)</td>
<td>$3,000/$6,000</td>
<td>$6,000/$12,000</td>
<td></td>
</tr>
</tbody>
</table>

- You pay 10%
- You pay 20%
- You pay 35%
- You pay 20%
- You pay 35%
- You pay 20%
- You pay 10%
- You pay 20%
- You pay 35%
- You pay 20%
- You pay 35%
- You pay 20%

Limit of 60 combined treatments per calendar year, after the deductible

- 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)

- Retail (30-day supply): $10/$30/$50 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

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1**PCP** = 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.”

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.

Aetna Healthy Home Visit
Medicare Advantage
Aetna’s Healthy Rewards Program is designed with your health and happiness in mind. By completing a Healthy Home Visit, you can earn and choose a $100 gift card to participating large retail, grocery, or restaurant merchants. An Aetna Healthy Home Visit typically involves a healthcare professional, such as a nurse or a community health worker, visiting your home to provide personalized health assessments, education, and support. Call 1.877.503.5802, or go to Schedule.SignfyHealth.com to schedule an appointment today.

Hinge Health
Maroon PPO, Maroon Savings Choice, UCHP Plan
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 call 855.902.2777, or go to:
- Maroon Plans: www.hingehealth.com/uchicago
- UCHP Plan (Aetna® Back and Joint powered by Hinge): www.hingehealth.com/find/aetna/

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)
- Call the Social Security office 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:
  
  Mail:  Human Resources – Benefits
  Attention: Retiree Medical Plan
  6054 S. Drexel Ave.
  Chicago, IL 60637
  
  Email:  retiree@uchicago.edu
  Fax: 773.834.0996

Upon the death of a retired employee or dependent
- 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, 2024

Medicare Eligible — Table A

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Medicare Advantage</th>
<th>Medicare Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>One person age 65 or older</td>
<td>$264</td>
<td>$399</td>
</tr>
<tr>
<td>Two people age 65 or older</td>
<td>$529</td>
<td>$798</td>
</tr>
</tbody>
</table>

Non-Medicare Eligible — Table B

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Maroon PPO</th>
<th>Maroon Savings</th>
<th>UCHP</th>
<th>BCBS HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>One person under age 65</td>
<td>$808</td>
<td>$689</td>
<td>$598</td>
<td>$465</td>
</tr>
<tr>
<td>Two people under age 65</td>
<td>$1,617</td>
<td>$1,378</td>
<td>$1,197</td>
<td>$930</td>
</tr>
<tr>
<td>Three people under age 65</td>
<td>$2,425</td>
<td>$2,067</td>
<td>$1,795</td>
<td>$1,395</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Address</th>
</tr>
</thead>
</table>
| **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/retireemedicalplan.shtml](https://humanresources.uchicago.edu/benefits/retireemedicalplan.shtml) | 6054 S. Drexel Ave.  
Chicago, IL 60637 |
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  
caremark.com | 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](http://bcbsil.com) | |
| **HSA Bank — Maroon Savings Plan Health Savings Account Vendor** | Member Services: 800.357.6246  
[hsabank.com](http://hsabank.com) | |
| **Aetna — University of Chicago Health Plan (UCHP)** | Member Services: 855.824.3632  
[uchp.uchicago.edu](http://uchp.uchicago.edu) | |
| **CVS Caremark (Pharmacy) — UCHP, Maroon Savings and Maroon PPO Plans** | Member Services: 866.873.8632  
[caremark.com](http://caremark.com) | |
| **Prime Therapeutics (Pharmacy) — Blue Cross Blue Shield of Illinois HMO Plan** | Member Services: 800.423.1973  
[bcbsil.com](http://bcbsil.com) | |
| **TIAA (Record Keeper) — Retirement and Financial** | Member Services: 800.842.2252  
[TIAA.org](http://TIAA.org) | |
| **Perspectives — Staff and Faculty Assistance Program** | Member Services: 800.456.6327  
[perspectivesltd.com](http://perspectivesltd.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.
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 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.
• 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, 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 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 855.822.8901 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 855.822.8901 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 [www.healthcare.gov](http://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](http://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.askesba.dol.gov](http://www.askesba.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 July 31, 2023. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Mediicaid</td>
<td>Website: <a href="http://myahipp.com">http://myahipp.com</a></td>
<td>Phone: 1-855-692-5447</td>
<td></td>
</tr>
<tr>
<td>ALASKA – Mediicaid</td>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com">http://myakhipp.com</a></td>
<td>Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a></td>
<td></td>
</tr>
<tr>
<td>ARKANSAS – Mediicaid</td>
<td>Website: <a href="http://myarhipp.com">http://myarhipp.com</a></td>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA – Mediicaid</td>
<td>Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hip">http://dhcs.ca.gov/hip</a></td>
<td>Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a></td>
<td></td>
</tr>
<tr>
<td>GEORGIA – Mediicaid</td>
<td>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a></td>
<td>Phone: 678-564-1162 Press 1</td>
<td></td>
</tr>
<tr>
<td>INDIANA – Mediicaid</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.indiana.gov/fssa/hip">http://www.indiana.gov/fssa/hip</a></td>
<td>Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid">https://www.in.gov/medicaid</a> All other Medicaid Phone: 1-800-457-4584</td>
<td></td>
</tr>
<tr>
<td>IOWA – Medicaid</td>
<td>Website: <a href="https://www.kancare.ks.gov">https://www.kancare.ks.gov</a></td>
<td>Phone: 1-800-338-8366</td>
<td></td>
</tr>
<tr>
<td>KANSAS – Medicaid</td>
<td>Website: <a href="https://www.kancare.ks.gov">https://www.kancare.ks.gov</a></td>
<td>Phone: 1-800-338-8366</td>
<td></td>
</tr>
<tr>
<td>KENTUCKY – Medicaid</td>
<td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/khipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/khipp.aspx</a></td>
<td>Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a></td>
<td></td>
</tr>
<tr>
<td>LOUISIANA – Medicaid</td>
<td>Website: <a href="https://www.medicaid.la.gov">https://www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a></td>
<td>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</td>
<td></td>
</tr>
</tbody>
</table>
To see if any other states have added a premium assistance program since July 31, 2023, 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

OMB Control Number 1210-0137 (expires 1/31/2026)
Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can’t balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

• You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

• Your health plan generally must:
  • Cover emergency services without requiring you to get approval for services in advance (prior authorization).  • Cover emergency services by out-of-network providers.  • Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.  • Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, or for more information about your rights, you may file a complaint with the federal government and access more information at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059.
Notes