2025

Retiree Medical Guide

THE UNIVERSITY OF CHICAGO | HUMAN RESOURCES

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 25 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, 2025. 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 2025: Starting January 1, 2025 we will make the following changes to the plans to keep up with medical inflation, comply with changes to the Medicare Part D legislation, and to keep premium increases down:

- Medicare Advantage Plan
  - The out-of-pocket maximum will increase from $1,000 to $1,500.
  - You will see a 5.4% increase in your premiums largely due to bad claims experience. The change to the out-of-pocket maximum is being added to reduce the increase which was originally 10.4%.
- Medicare Supplement Plan
  - The out-of-pocket maximum will increase from $1,750 to $2,250.
  - There will be no increase to your premiums because of the small plan design change.
- Medicare Pharmacy Coverage
  - Both the Advantage and Supplement Plans will add a $200 individual pharmacy deductible outlined on page 10 of your guide.
  - Your out-of-pocket maximum will decrease from $7,750 to $2,000.
  - The government has added a program that would allow you to spread pharmacy spend out over the year. You will receive information in the mail on how to enroll in the program. NOTE: You do not need to enroll. The program is designed for Retirees who have high out-of-pocket drug costs. Since we have a copay program which limits your out-of-pocket costs, you can choose to continue to pay at the pharmacy.
- 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.

Sincerely,

Elizabeth Walls

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

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.

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/login**

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.

You may also download the Enrollment Form at: https://humanresources.uchicago.edu/benefits/retireemedicalplan.shtml.

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 Postponement 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.

You may also download the Postponement Form at: https://humanresources.uchicago.edu/benefits/retireemedicalplan.shtml.

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.

	Eligible for Medicare	Not Eligible for Medicare
Who is Eligible	• 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	• Retirees and their eligible dependents younger than age 65 • Retirees living outside of the United States (Maroon Plans only)
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

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:

	Aetna Medicare Advantage Plan
Overview of the 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.
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**.
When you get care	• Present your Aetna ID card; **do not use your Medicare card** • 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	1. Pay your provider the applicable copay. 2. Your provider will file your claim with Aetna. 3. Aetna processes your claim in accordance with Medicare Part A and B benefits. 4. You will receive an Explanation of Benefits (EOB) from Aetna. 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.

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 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℠ Plan (PPO) with Extended Service Area (ESA)	Medicare Supplement Plan Traditional Choice
Deductible per individual	$150	$300
Out-of-pocket maximum per individual*	$1,500 (includes deductible, copays and coinsurance)	$2,250 (includes deductible and coinsurance)
Office visits (Primary Care Physician/Specialist)	$10/$30 copay after the deductible	10% coinsurance after the deductible
Preventive care	100% covered	100% covered
Lab work	100% covered after the deductible	10% coinsurance after the deductible
X-rays	$30 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
Outpatient Rehabilitation Services (Speech/physical/occupational therapy)	$30 copay	10% coinsurance after the deductible
Urgent care	$65 copay	10% coinsurance after the deductible
Emergency room	$100 copay	10% coinsurance after the deductible
Prior authorization	May be required	Not required
Routine dental care	$0 deductible $750 annual benefit maximum Preventive dental services including basic cleanings, checkups and X-rays	Not included
Vision services	Routine Eye Exams: $0; 1 every 12 months Diabetic Eye Exams: $0 Medicare Covered Eye Exam: $30	Routine Eye Exam: 100% covered 1 routine eye exam per 12 months
Hearing aids	Reimbursable up to $2,000 every 24 months	10% coinsurance after the deductible up to $2,000 every 24 months
Additional benefits/coverage	SilverSneakers® fitness program Routine hearing services Routine foot care Video doctor visits (telemedicine) Non-Emergency Transportation	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

** 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 24).

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.

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 24) 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:

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

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.

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

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.

Prescription Drugs (in-network)	**Retail Pharmacy** (30-day supply)	**Home Delivery/ Mail Order Pharmacy** (90-day supply)	**Retail Pharmacy** (90-day supply)
Deductible per individual	$200 (Retail/Home Delivery/Mail Order Combined)		
Generic Copay	You pay $10, after deductible	You pay $20, after deductible	You pay $30, after deductible
Preferred Brand Copay	You pay $30, after deductible	You pay $60, after deductible	You pay $90, after deductible
Non-Preferred Brand Copay	You pay $50, after deductible	You pay $100, after deductible	You pay $150, after deductible
Specialty Copay	You pay $75, after deductible	You pay $150, after deductible	You pay $225, after deductible

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/Preferred Network Retail Pharmacy	Generally used to fill long-term maintenance prescriptions for ongoing conditions, such as asthma, diabetes, and high blood pressure. Home delivery/ mail order or Preferred Retail Pharmacy is a convenient and cost-effective way to obtain a 90-day supply. Preferred Network Retail Pharmacy includes CVS and DCAM pharmacies. If you elect home delivery: • 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.

New 2025 Prescription Drug Features

The new Medicare prescription law caps your out-of-pocket costs at $2,000 in 2025 and eliminates the coverage gap (known as the donut hole). This means you will never pay more than $2,000 in out-of-pocket drug costs.

The amount that is applied to your out-of-pocket may not be the deductible and copay amounts under The University of Chicago SilverScript retiree drug plan. Instead, the amount that applies to the true out-of-pocket (TrOOP) is the greater of your deductible/copay amounts or the cost under the CMS Defined Standard Plan as shown in the example below:

CMS Defined Standard Plan Costs	
Deductible Phase	$590
Initial Phase	25% coinsurance
Catastrophic Phase (after $2,000)	$0

Rx Cost	Tier	Plan Design w/$200 Deductible (Actual Amt. Paid by Retiree)	CMS Phase	Amount Applied to TrOOP
Script 1: $590	Preferred Brand	$260 (University deductible + copay)	Deductible	$590
Script 2: $2,200	Specialty	$150	Initial	$550
Script 3: $3,440	Specialty	$150	Initial	$860
Script 4: $1,500	Non-Preferred Brand	$0	Catastrophic	N/A
Total		**$560**		**$2,000**

In this example, you reach your out-of-pocket maximum after you pay only $560 (and not $2,000).

In addition, you have the **option** to participate in a new payment plan which spreads your drug cost across monthly payments that vary throughout the year. If you select this option, instead of paying for your medications when you receive them, you will get a bill directly from SilverScript for your out-of-pocket prescription drug expenses. Please note the following:

- This option may help you manage expenses, but it does not save you money or lower your drug costs.
- When you fill a prescription, you will not pay the pharmacy (including mail order and specialty pharmacies). Instead, you will receive a separate bill each month from the plan. This bill is based what you owe for any prescriptions you receive that month plus your previous month's balance, divided by the number of months left in the year.
- **It is important to note that your payments might change every month so you will not know what your exact bill will be ahead of time.** Future payments may increase when you fill or refill a prescription because as new out-of-pocket costs are added into your monthly payment, there are fewer months left in the year to spread out your payments.
- If you do not pay the required monthly payment, you will be removed from the payment program and be required to pay the pharmacy directly for any out-of-pocket drug costs.
- This option may not be right for you if your yearly drug costs are low or if you are satisfied paying for your drugs as you receive them.

Below is an example of how the payment program works for a member who enrolls in the program at the start of the year and fills a 90-day supply at mail the first month of each quarter. **The example does not include the TrOOP adjustment, but assumes the deductible/copay equal the actual cost of the medication**.

Medications filled each quarter:

- Generic: 3 prescriptions
- Brand Formulary: 2 prescriptions
- Brand Non-Formulary: 2 prescriptions
- Specialty: 2 prescriptions

	Amount Paid Each Month	
Payment Amounts:	Without Payment Plan	With Payment Plan
Jan	$680.00	$166.67[1]
Feb	$0.00	$46.67[2]
Mar	$0.00	$46.67
Apr	$680.00	$122.22
May	$0.00	$122.22
Jun	$0.00	$122.22
Jul	$640.00	$228.89
Aug	$0.00	$228.89
Sep	$0.00	$228.89
Oct	$0.00	$228.89
Nov	$0.00	$228.89
Dec	$0.00	$228.89
Full Year	**$2,000.00**	**$2,000.00**

[1] First Month Cap = (Annual OOP Threshold – Incurred Costs of the Participant) / Number of Months Remaining in the Plan Year OR ($2,000 - $0) /12 = $166.67
[2] Subsequent Month Cap = (Sum of Remaining OOP Costs Not Yet Billed to Participant + Additional OOP Costs Incurred by the Participant) / Number of Months Remaining in the Plan Year OR ($680.00 - $166.67 + $0) / 11 = $46.67

If you have any questions regarding the optional payment plan, please contact SilverScipt Member Services.

Medical Benefits If You Are NOT Eligible

Medical

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 20–21 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

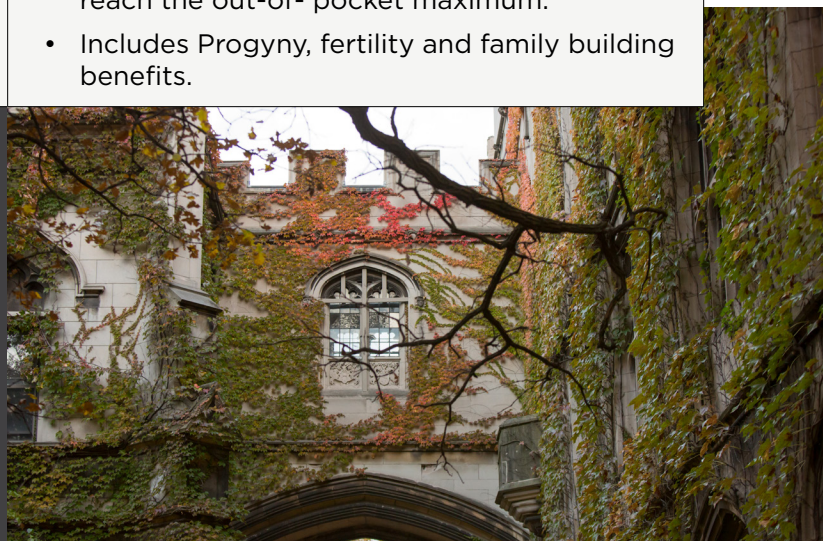
If you prefer an HMO, keep in mind these key differences as you consider the two HMO options:

University of Chicago Health Plan (UCHP)	Blue Cross Blue Shield HMO Illinois (HMO Illinois)
• 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. For a complete list of UCMC facilities visit https://www.uchicagomedicine.org/find-a-location. • NorthShore Health System's network of hospitals and providers are additional provider options available to you. For a complete listing of NorthShore locations visit https://www.northshore.org/locations/. • AdventHealth network available to you in Bolingbrook, Glendale Heights, Hinsdale, and LeGrange. To find a full list of locations and physicians, visit UChicagoMedicine.org. • Services received outside of the three provider options above will not be covered unless it is an emergency	• You have access to the Blue Cross Blue Shield (BCBS) 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 and your covered dependents must live in its service area and you must use doctors in the network and within your service area** unless it is an emergency. • **UCMC PCPs are not currently in the BCBS HMO network.** • Includes vision coverage with EyeMed. An in-network provider must be used to receive the benefit.

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)
• 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. • Includes Progyny, fertility and family building benefits.	• 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. • Includes Progyny, fertility and family building benefits.

You can review the Summary of Benefits and Coverage and glossary online at **https://humanresources.uchicago.edu/benefits/nonmedicareeligible.shtml**, or you can request a paper copy, free of charge, through the Benefits Office at 855.822.8901 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 20-21 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 2025 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 2025, you can contribute:

Contributions	Individual	Family
2025 IRS maximum	$4,300	$8,550

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

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 2024 and will open an HSA for 2025, make sure to use all the funds in your FSA by December 31, 2024. Using all your FSA funds by December 31, 2024 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.

	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
Virtual Primary Care through Teladoc	n/a	n/a
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])	• Retail (30-day supply): $10/$30/$50 copayment; 50% copayment for maintenance medications after second refill (not applicable if filled by DCAM[4] pharmacy) • Retail at DCAM[4] and Ingalls[5] pharmacies (30-day supply): $5/$15/$30 copayment • 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 • Mail service at DCAM[4] and Ingalls[5] pharmacies (90-day supply): $10/$30/$60 copayment • Mail service with CVS Caremark (90-day supply): $20/$60/$100 copayment Administered by CVS Caremark	• 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

[1]PCP = Primary care physician.
[2]You are also responsible for 100% of the charges in excess of the prevailing fee schedule.
[3]100% applies to the surgery only; doctor visits subject to applicable coinsurance.
[4]DCAM = Duchossois Center for Advanced Medicine at the University of Chicago Medicine.
[5]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)			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]
You pay 10%	You pay 20%	n/a	You pay 20%	n/a
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)	
• 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			• 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	

[1]PCP = Primary care physician.
[2]You are also responsible for 100% of the charges in excess of the prevailing fee schedule.
[3]100% applies to the surgery only; doctor visits subject to applicable coinsurance.
[4]DCAM = Duchossois Center for Advanced Medicine at the University of Chicago Medicine.
[5]Specialty 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. 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.

To get started or learn more, register through bcbsil.com or download the Well onTarget mobile app and click "New User Registration."

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: my.hingehealth.com/onboarding/uchicago/registration
- UCHP Plan (Aetna® Back and Joint powered by Hinge): www.hingehealth.com/find/aetna/

Teladoc Health

Maroon PPO, Maroon Savings Choice

Teladoc Health 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 teladochealth.com/go/theuniversityofchicago.

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 SignifyHealth.com to schedule an appointment today.

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.

New Program!

UCHP's Hinge Health will now include **Hinge Pelvic Program:** virtual physical therapy for women's pelvic health. With Hinge Health, you'll get a personalized care plan that addresses your unique symptoms and life stage. Reduce pelvic pain and discomfort with exercise sessions you can do at home in 15 minutes or less.

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, 2025

Medicare Eligible — Table A

Coverage Level	Medicare Advantage	Medicare Supplement
One person age 65 or older	$278	$399
Two people age 65 or older	$557	$798

Non-Medicare Eligible — Table B

Coverage Level	Maroon PPO	Maroon Savings	UCHP	BCBS HMO
One person under age 65	$878	$754	$618	$481
Two people under age 65	$1,756	$1,509	$1,236	$962
Three people under age 65	$2,634	$2,263	$1,853	$1,444

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/retireemedicalplan.shtml	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 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	
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	
TIAA (Record Keeper) — Retirement and Financial	**Member Services:** 800.842.2252 TIAA.org	
Perspectives — Staff and Faculty Assistance Program	**Member Services:** 800.456.6327 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.

Notices

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

Medicare Part D Creditable Coverage

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to KEEP your University of Chicago prescription drug coverage and enroll in a Medicare prescription drug plan, your University of Chicago coverage generally will be your primary coverage. You may be required to pay a Medicare Part D premium in addition to your University of Chicago medical plan contributions.

If you do decide to join a Medicare drug plan and DROP your current University of Chicago prescription drug coverage—by dropping your medical plan, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

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

For More Information about Your Options under Medicare Prescription Drug Coverage

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

For more Information about Medicare Prescription Drug Coverage:

- Visit medicare.gov.
- 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.

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 July 31, 2024. 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: https://health.alaska.gov/dpa/Pages/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
Fax: 916-440-5676
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://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

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

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid
http://www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
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: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840 / TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

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
Email: HHSHIPPProgram@mt.gov

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/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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: https://www.hhs.nd.gov/healthcare
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
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 1-800-986-KIDS (5437)

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program
CHIP Website: https://chip.utah.gov

VERMONT– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms
http://mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

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

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

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

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