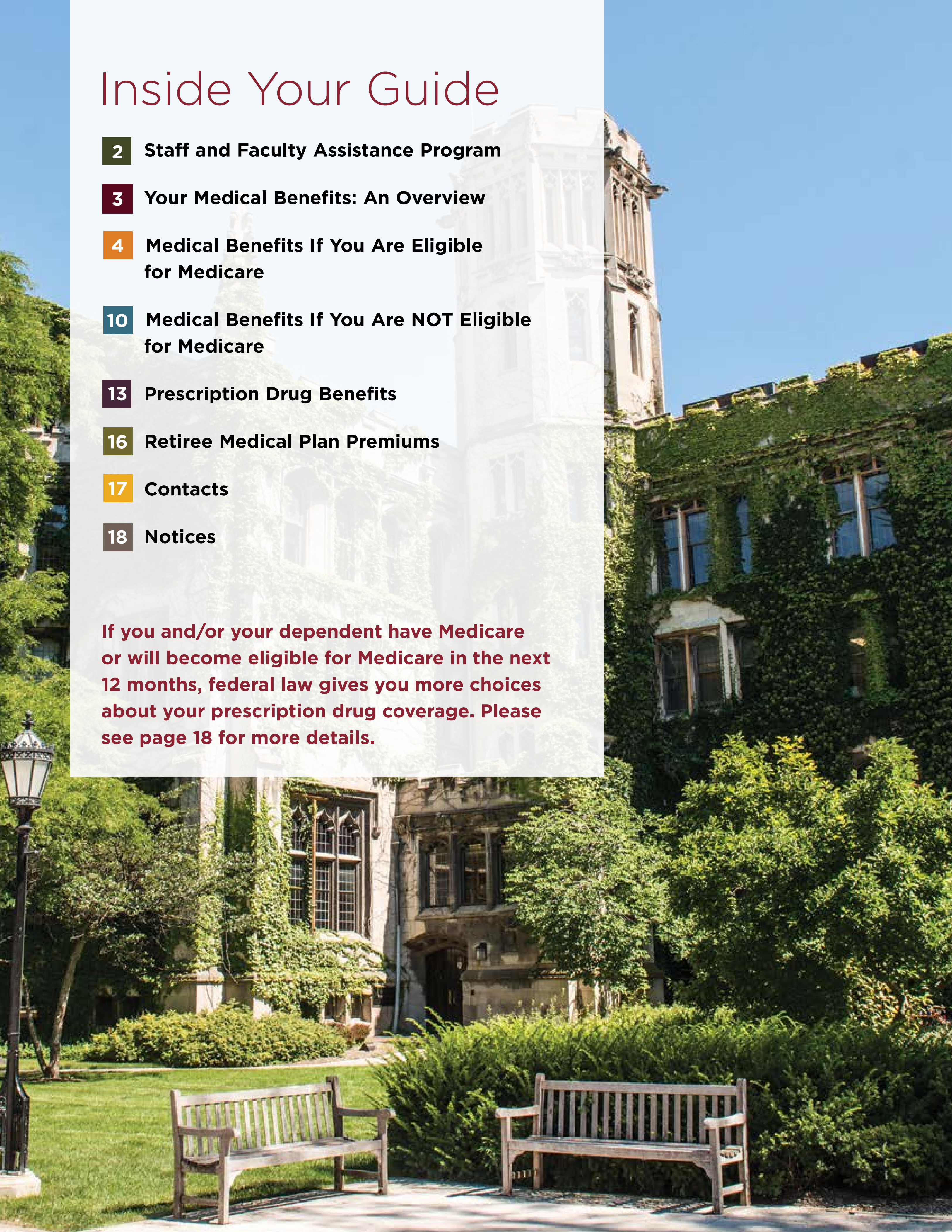
2021 Retiree Medical Plan



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

Dear Retiree Medical Plan Participant:

This Retiree Medical Plan Guide provides you with information regarding your medical and prescription drug coverage **effective January 1, 2021**. 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**, your medical coverage will continue to be provided through a Preferred Provider Organization (PPO) plan administered by Blue Cross and Blue Shield of Illinois (BCBSIL).

New for 2021: Starting January 1, 2021 prescription drug coverage will be provided by CVS Caremark®. Moving to CVS Caremark will allow the University to leverage our larger covered population to help keep your premium lower. See page 13 for more details.

Questions?

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

Sincerely,

Elizabeth Walls

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

Eligibility for the Retiree Medical Plan

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

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

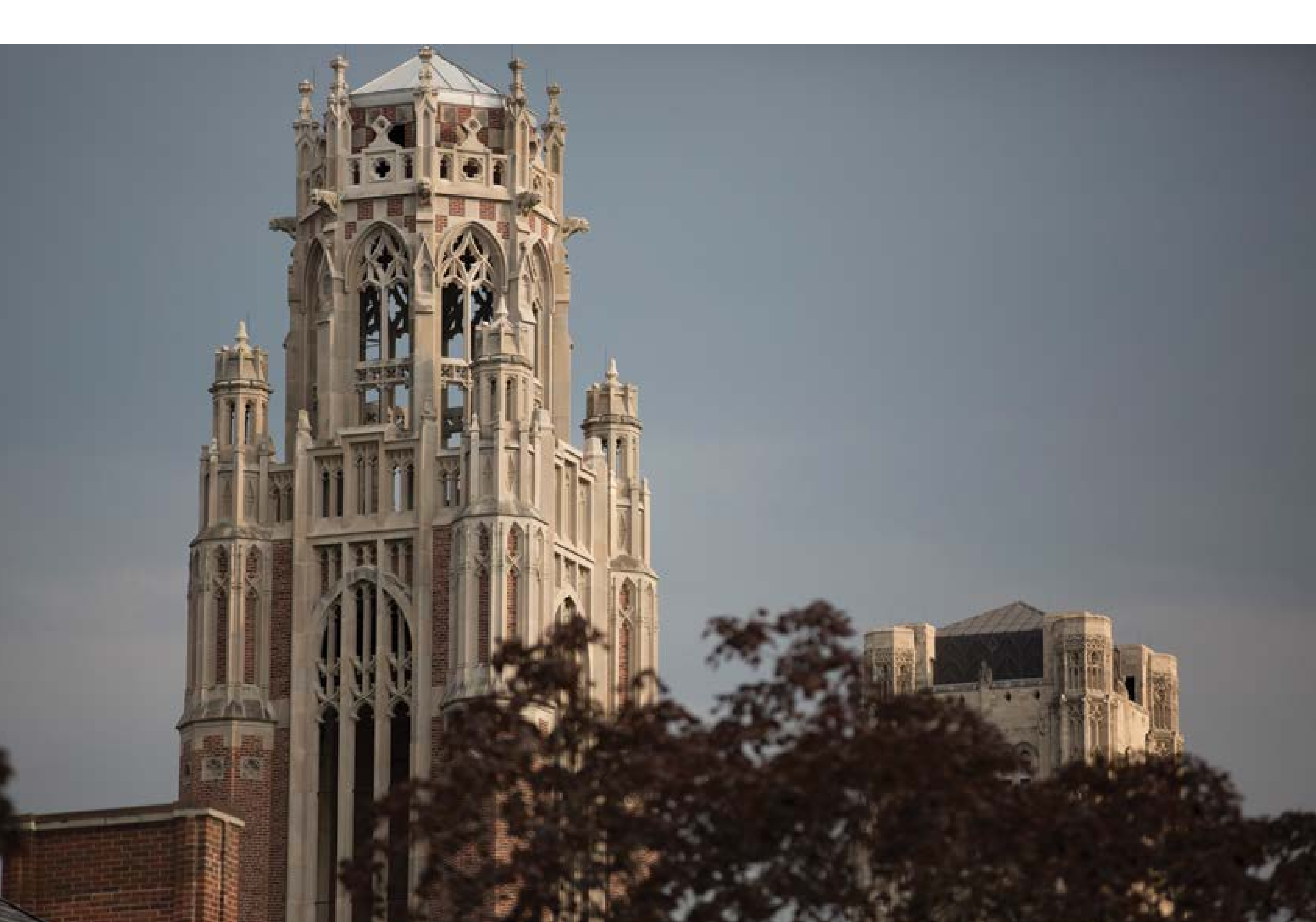
Staff and Faculty Assistance Program

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

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

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

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



Your Medical Benefits: An Overview

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

	Eligible for Medicare	Not Eligible for Medicare
Who is Eligible	• 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
Medical Plan	• Choice of two Retiree Medical Plans administered by Aetna®	• Retiree Medical Plan administered by Blue Cross and Blue Shield of Illinois (BCBSIL)
For More Information	• See page 4	• See page 10

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

Split Families

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

Reminder: New Bill Pay Administrator

The University of Chicago transitioned the Retiree Bill Pay Administrative Services to Discovery Benefits (DBI) effective July 1, 2020. Bill Pay payments should be sent to DBI and not WageWorks.

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

If you have any questions, please contact Discovery Benefits at 866.451.3399 or cobraadmin@discoverybenefits.com.

Medical Benefits If You Are Eligible

The University offers Medicare-eligible retirees the choice of two medical plans, both administered by Aetna®: the Medicare Advantage Plan or the Medicare Supplement Plan. If you would like to make changes to the plan that you selected, complete and return the enrollment form included in this package to the Benefits Office by November 30, 2020. If you are not making changes, you will remain on your current plan and do not need to complete the enrollment form. You will only be able to change plans each year during Open Enrollment.

Understanding the Medicare Advantage Plan vs Medicare Supplement Plan

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

	Aetna Medicare Advantage Plan
Overview of the plan	• 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. Sometimes providers send bills right away, but you should wait for the next bill that comes after you have received your EOB.

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 800.556.1555.

Aetna Medicare Supplement Plan

- The Medicare Supplement Plan coordinates payments with Medicare Part A and B and supplements the Medicare coverage by paying additional amounts not covered.
- Medicare provides your primary medical coverage and pays first.
- The Aetna Medicare Supplement Plan will process second and pay additional amounts not covered by Medicare.

- **Your medical services must be provided by a doctor who accepts Medicare**.
- Aetna® will process your claim under the terms of the Retiree Medical Plan once it knows the amount that Medicare has covered and paid.

- Present your red, white, and blue Medicare ID card **and** Aetna ID card.

1. Your provider will file your claim with Medicare.
2. You will receive a Medicare Summary Notice (MSN) showing how much Medicare pays and how much you owe; you do not need to pay until after Aetna processes the claim.
3. The claim submitted to Medicare is automatically sent to Aetna for processing. The Aetna Medicare Supplement Plan may help pay for some or all of the costs not paid by Medicare.
4. You will receive an Explanation of Benefits (EOB) showing how much Aetna paid and how much you may owe.
5. After your claim has gone through both Medicare and Aetna, you will receive a bill from your provider for any remaining amount.
6. Pay your provider directly for the portion of the cost (if any) **only after you have received** both your MSN and EOB. Sometimes providers send bills right away, but you should wait for the next bill that comes after you have received your MSN and EOB.

The Aetna Medicare Plans

Compare the Plans

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

Plan Provision	Aetna Medicare Advantage Plan	Aetna Medicare Supplement Plan
Deductible per individual	$150	$300
Out-of-pocket maximum per individual*	$1,000 (includes deductible, copays and coinsurance)	$1,750 (includes deductible and coinsurance)
Office visits (Primary Care Physician/Specialist)	$10/$35 copay after the deductible	10% coinsurance after the deductible
Preventive care	100% covered	100% covered
Lab work	100% covered after the deductible	100% covered after the deductible
X-rays	$35 copay after the deductible	10% coinsurance after the deductible
Durable medical equipment	10% coinsurance after the deductible	10% coinsurance after the deductible
Inpatient hospital	$250 copay per admission after the deductible	$250 copay, then 10% coinsurance after the deductible
Outpatient hospital	$50 copay after the deductible	10% coinsurance after the deductible
Urgent care	$65 copay	10% coinsurance
Emergency room	$100 copay	10% after the deductible
Prior authorization	May be required	Not required
Additional benefits/ coverage	• SilverSneakers® fitness program • Routine vision care • Routine hearing services • Hearing aid coverage • Video doctor visits (telemedicine) • Routine foot care	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 assignments before receiving services. Aetna® cannot pay a provider that does not accept or has opted out of Medicare. If you receive care from one of these providers, you will be responsible for the full medical bill without reimbursement.

Finding In-Network Providers

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

- **Call Aetna® 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 17).

Care When Traveling Outside the U.S.

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

Medicare Part D Prescription Coverage

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

For information on your prescriptions or to find a CVS Caremark participating retail network pharmacy near you, visit caremark.com. You can also call CVS Caremark at 833.958.2658. See page 13 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 atenaretireeplans.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.

Prior Authorization

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

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

Understanding Your Explanation of Benefits (EOB)

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

The Aetna Medicare Advantage Plan EOB has three sections:

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

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

New Benefits Added for 2021

The Medicare Advantage Plan provides the following new benefit coverages for 2021:

- **Acupuncture** for chronic lower back pain when performed by a recognized provider, up to 20 visits per year.
- **Telehealth** covers primary care physician or urgent care/walk-in clinic under your PCP copay at the following clinics: Walgreens Healthcare Clinic, The Little Clinic at Kroger's, Redi Clinic, FastCare Clinic, Walmart Care Clinic, and CVS MinuteClinic®.
- **Transportation benefit** through Access2Care provides safe transportation to and from medical appointments, up to 24 trips with unlimited miles per trip.

Aetna Medicare Supplement Plan

How to Access Care

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

Explanation of Benefits (EOB)

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

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

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

Medicare Direct

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

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

Additional Benefits

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

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

Once you are a member, go to aetna.com for more information.

Medical Benefits If You Are NOT Eligible for Medicare

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

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

When You Get Care

Show your ID card	• Present your BCBSIL Retiree Medical Plan ID card to providers.
The claim is automatically sent to BCBSIL for processing	• Your in-network provider automatically sends your claim to BCBSIL for processing. • You will receive an Explanation of Benefits (EOB) showing how much the plan pays and how much you may owe.
Wait for the bill from your provider	• After your claim has gone through BCBSIL, you will receive a bill from your provider for any remaining amount. • Pay your provider directly for your portion of the cost (if any) only **after you have received** your EOB. Sometimes providers send bills right away; however, you should wait to receive your EOB before you pay your bill.

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

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

[1] *Any expenses applied to your deductible during October, November, or December can carry over into the next year.*

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

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

Hospital Services

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

Care When Traveling Outside the U.S.

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

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

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

To receive reimbursement, complete a BGC International claim form and send it with the itemized bill(s) for all services to the BGC Service Center. BGC claim forms are available at bcbsglobalcore.com. You are responsible for 100% of all non-covered services.

24/7 Nurseline

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

Prescription Drug Benefits

The non-Medicare eligible retiree drug coverage will be provided by CVS Caremark®, which has an extensive network of 65,000 pharmacies. The Medicare eligible retirees will have coverage with SilverScript®, which is licensed by CVS Health®. Your Express Scripts coverage will end on December 31, 2020.

There will be some changes with the new coverage:

- A new drug formulary (the list of covered prescription drugs) with minor differences to the Express Scripts formulary*
- Some prescription drugs may be classified under a different coverage tier

The chart below provides additional details based on your non-Medicare or Medicare eligibility:

Non-Medicare Eligible	Medicare Eligible
• Covered prescription drugs will be based on the CVS Caremark formulary used by the Blue Cross Blue Shield Maroon PPO and Maroon Savings Choice Plans	• Covered prescription drugs will be based on the SilverScript formulary, specifically set up to work with the CMS-approved Medicare Part D drug list • You will receive two CMS-required letters: » Express Scripts letter informing you that your coverage is terminated as of December 31, 2020 » SilverScript letter with information on your new coverage effective January 1, 2021

** If you are taking a drug that is not covered under the new formulary, you will receive a letter regarding your options and any actions needed in order to continue coverage for that specific medication.*

Will I need to get all new mail order prescriptions?

Express Scripts (ESI) will transfer most mail order and specialty pharmacy prescriptions to CVS Caremark® Mail Service Pharmacy,/ CVS Specialty® or SilverScript. ESI cannot transfer prescriptions with no refills, expired prescriptions, or prescriptions for controlled medications.

Will I need to change my retail pharmacy?

- **Medicare-eligible retirees:** You can get a 30-day or a 90-day prescription at any network pharmacy. However, you will pay lower copays if you get a 90-day supply at a CVS Pharmacy®, CVS Target, Long's, or the mail-order pharmacy.
- **Non-Medicare eligible retirees:** You can get a 30-day prescription at any network pharmacy. However, if you are currently receiving a 90-day supply of a drug at a Walgreens retail pharmacy, you will have to move your prescription to a CVS Pharmacy or to CVS Caremark Mail Service Pharmacy to continue receiving a 90-day supply.

Prescription Drug ID Cards

Prior to January 1, 2021, you will receive new ID card(s) from CVS Caremark® or SilverScript®. **You must provide the pharmacy with your new card starting January 1, 2021 and let them know your coverage has changed. Otherwise, the pharmacy will try to process under the card on file and benefits will be denied.**

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

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

Where to fill your prescriptions

Retail Pharmacy	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 Choice Program

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 at the same mail-order copay and discounts.

Note: 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 the phone number on your card.

! Take note

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

Retiree Medical Plan Premiums

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

When you take the following actions (premiums reflect the lower, 65-and-older rate)	• Call 800.772.1213 to enroll in Medicare Parts A and B three months prior to your 65th birthday, and • Send a copy of your Medicare card showing Part A and Part B coverage to: 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, 2021

Medicare Eligible — Table A

Coverage Level	Medicare Advantage	Medicare Supplement
One person age 65 or older	$216	$319
Two people age 65 or older	$433	$638

Non-Medicare Eligible — Table B

Coverage Level	BCBSIL PPO
One person under age 65	$665
Two people under age 65	$1,330
Three people age 65	$1,995

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

	Customer Service	Address
University of Chicago Human Resources Benefits Office	**Phone:** 855.822.8901 **Fax:** 773.834.0996 **Email:** retiree@uchicago.edu **Website:** https://humanresources.uchicago.edu/benefits/	6054 S. Drexel Ave. Chicago, IL 60637
Aetna Medicare Advantage Plan	**Member Services (8 a.m. - 6 p.m.):** 888.267.2637 www.aetnaretireeplans.com	PO Box 981106 El Paso, TX 79998-1106
Aetna Medicare Supplement Plan	**Member Services (24 hours):** 800.238.6716 www.aetna.com	PO Box 981106 El Paso, TX 79998-1106
Blue Cross and Blue Shield of Illinois — Medical Plan Not Eligible for Medicare	**Customer Service (24 hours):** 866.390.7772 **Nurseline:** 800.299.0274 **PPO Provider Finder:** bcbsil.com/providers	Claims Processing PO Box 1220 Chicago, IL 60690-1220
Discovery Benefits, Inc. (Retiree Medical Plan billing administrator)	**Customer Service:** 866.451.3399 cobraadmin@discoverybenefits.com https://cobra.discoverybenfits.com	PO Box 2079 Omaha, NE 68103-2079
SilverScript — Medicare eligible Retiree Prescription Plan	**Customer Service:** 833.958.2658	P.O. Box 52066 Phoenix, AZ 85072-2066
CVS Caremark — Non-Medicare eligible Retiree Prescription Plan	**Customer Service:** 866.873.8632	PO Box 52136 Phoenix, AZ 85072-2136

Take note

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

Notices

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

Medicare Part D Creditable Coverage

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

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

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

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

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current University of Chicago prescription drug coverage will be affected.

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact the Benefits Office at 773.702.9634 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through the University of Chicago changes. You also may request a copy of this notice at any time.

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

For more Information about Medicare Prescription Drug Coverage:

- Visit medicare.gov.
- 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 773.702.9634.

HIPAA Notice of Special Enrollment Rights

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

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

Special Enrollment Provisions

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you gain a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your new dependents in the Plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse in the Plan, if your spouse was not previously covered. Please contact the Benefits Office at 773.702.9634 for details, including the effective date of coverage added under this special enrollment provision.

Enrollment Due to Medicaid/CHIP Events

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

Contact Information

If you have any questions about this Notice or about how to enroll in the Plan, please contact the Benefits Office at 773.702.9634 or by writing to:

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. 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 ProgramWebsite: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arkansas - Medicaid

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

California - Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

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

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plusCHP+
Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

Florida - Medicaid

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

Georgia – Medicaid

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

Indiana - Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

Iowa - Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid
Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

Kansas - Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

Kentucky - Medicaid

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

Louisiana - Medicaid

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

Maine- Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

Massachusetts - Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

Minnesota - Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

Missouri - Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana - Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

Nebraska - Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada - Medicaid

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

New Hampshire - Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

New Jersey - Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

New York - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/**Phone:** 1-800-541-2831

North Carolina - Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

North Dakota - Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

Oklahoma - Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon - Medicaid

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

Pennsylvania - Medicaid

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

Rhode Island - Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

South Carolina - Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas - Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

Utah - Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/
CHIP Phone: 1-877-543-7669

Vermont - Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

Virginia - Medicaid and CHIP

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

Washington - Medicaid

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

West Virginia - Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin - Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/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, 2020, 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 12/31/2021)

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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