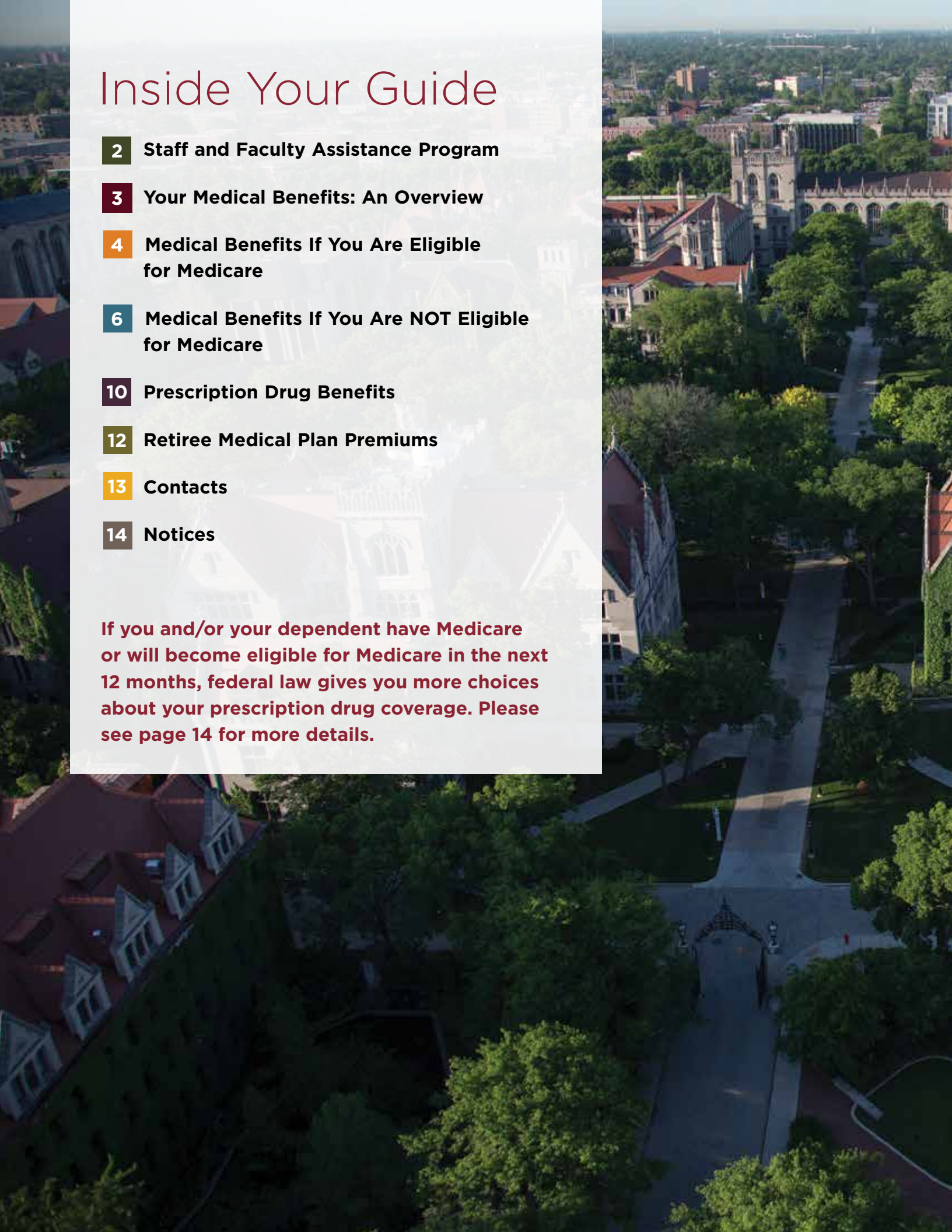
2019

Retiree Medical Plan

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 14 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, 2019**. This guide also contains important information about your rights and responsibilities.

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

Those eligible for Medicare will receive information from Anthem Blue Cross Blue Shield in the coming weeks.

Questions?

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

Sincerely,

Maria Garcia

Maria E. Garcia
Director, Health & Welfare and Retirement
Human Resources

Staff and Faculty Assistance Program

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

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

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

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

Your Medical Benefits: An Overview

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

	If You Are Eligible for Medicare	If You Are Not Eligible for Medicare
Who's 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	• Retiree Medical Plan administered by Anthem Blue Cross Blue Shield	• Retiree Medical Plan administered by Blue Cross and Blue Shield of Illinois (BCBSIL)
For More Information	• See page 4	• See page 6

Both of the plans under the Retiree Medical Plan are Preferred Provider Organization (PPO) plans.

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 Anthem Medicare Advantage PPO. The family member who is not eligible for Medicare will be covered by the current BCBSIL PPO.

Medical Benefits If You Are Eligible for Medicare

If you and your covered dependents are age 65 and older or under age 65 and enrolled in Medicare, your medical coverage through the Retiree Medical Plan is a Medicare Advantage plan, also known as Medicare Part C. This plan will be administered by Anthem Blue Cross Blue Shield and requires that you be enrolled in both Medicare Part A and Part B.

Are You Eligible for Medicare?
If you answered no, turn to page 6 to read about your medical plan coverage.

The Anthem Medicare Preferred Provider Organization (PPO) Plan uses a network of healthcare providers and also gives you the freedom to see providers outside of the network. No referrals are required. Your medical plan pays the same benefit for in-network and out-of-network providers who accept Medicare. The chart on page 5 provides a summary of the coverage levels.

Other services available to you

The Anthem Medicare Advantage PPO provides additional benefits:

- SilverSneakers fitness program
- Routine vision care
- Routine hearing services
- Hearing aid coverage
- Video doctor visits/telemedicine (no charge)
- Routine foot care
- Additional annual physical exams

For more information, contact Anthem Blue Cross Blue Shield at 833.214.8952.

Coming in 2019: Dependent eligibility audit

In early 2019, the University of Chicago will conduct a dependent eligibility audit to ensure that only eligible dependents are covered under University medical plans. Participation in the audit is not optional and will require enrollee action. The Benefits Office will provide more information on the audit and required verification procedures in March 2019.

At a glance: Eligible for Medicare (Anthem Medicare Advantage PPO)

Plan Provision	You Pay
Annual Deductible	$300 (per family member; combined in-network and out-of-network deductible)
Individual Annual Out-of-Pocket Maximum*	$1,750 (per family member; includes annual deductible, copayments and coinsurance)
Preventive Care / Wellness	0%, no deductible
Physician Office Visits (non-preventive services)	10% coinsurance, after the deductible
Lab Work, X-rays	10% coinsurance, after the deductible
Hospital Services (Inpatient) Your provider must obtain prior authorization for planned procedures	$250 copayment per admission, after the deductible
Hospital Services (Outpatient) Your provider must obtain prior authorization for certain planned procedures	10% coinsurance, after the deductible
Emergency Room	$100 copayment per visit, no deductible
Urgent Care	$65 copayment per visit, no deductible

** Part D prescription copayments, routine hearing services, and foreign travel emergency and urgently needed care copayments and coinsurance are not included*

Be sure to confirm your providers accept Medicare assignments before receiving services. Anthem Blue Cross Blue Shield 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.

Medical Benefits If You Are NOT Eligible for Medicare

If you are not eligible for Medicare, the Retiree Medical plan provides primary medical coverage. This coverage may continue until you become eligible for Medicare, at which time your coverage under the Retiree Medical Plan will be the Anthem Medicare Advantage PPO plan.

Medical coverage 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.

Are You Eligible for Medicare?

If you answered yes, turn to page 4 to read about your medical plan coverage.

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
Individual 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.

Coming in 2019: Dependent eligibility audit

In early 2019, the University of Chicago will conduct a dependent eligibility audit to ensure that only eligible dependents are covered under University medical plans. Participation in the audit is not optional and will require enrollee action. The Benefits Office will provide more information on the audit and required verification procedures in March 2019.

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 two days.

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 BlueCard Worldwide (BCW) 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 BCW Service Center. For non-emergency inpatient medical care, you must contact the BCW Service Center to arrange for care from a BCW hospital.

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

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

24/7 Nurseline

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

Prescription Drug Benefits

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

Purchasing Your Prescriptions

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

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

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

Prescription Drugs	Express Scripts Retail Pharmacy (31-day supply)	Express Scripts Home Delivery/ Mail Order Pharmacy (90-day supply)	Express Scripts Retail Pharmacy (90-day supply)
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

Prescription Drug ID Cards

You will receive a separate Express Scripts ID card for your prescription drug benefits.

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

Where to fill your prescriptions

Retail pharmacy	Generally used to fill short-term prescriptions for temporary conditions. Short-term prescriptions are for a 31-day supply or less. Visit a participating retail pharmacy and present your ID card and prescription. To find an Express Scripts participating retail network pharmacy in your area, visit express-scripts.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 express-scripts.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, to Express Scripts at 800.837.0959.

! 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 have to pay an extra amount, Social Security will send a letter telling you what the extra amount will be 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, 2019

Level of coverage	Monthly premium
One person under age 65	$629.00
One person age 65 or older	$241.00
One person age 65 or older and one person under age 65	$870.00
Two persons under age 65	$1,258.00
Two persons age 65 or older	$482.00
Three or more persons all under age 65	$1,887.00
Three or more persons, including one person age 65 or older	$1,499.00
Three or more persons, including two persons age 65 or older	$1,111.00

! Take note

Faculty members who retired under the Faculty Retirement Incentive Program Early Retirement Option do not pay for premiums for themselves or their same- or opposite-sex spouse or civil union partner, or same-sex domestic partner (registered with the University on or before December 31, 2016) provided the spouse/partner is at least 65 years old and covered by Parts A and B of Medicare.

Contacts

	Customer Service Number	Address
University of Chicago Human Resources Benefits Office	**Phone:** 855.822.8901 **Fax:** 773.834.0996 **Email:** retiree@uchicago.edu	6054 S. Drexel Ave. Chicago, IL 60637
Anthem Blue Cross Blue Shield — Medical Plan Eligible for Medicare	**First Impressions:** 833.214.8951 Through 12/31/18 **Customer Service:** 833.214.8952 Effective 1/1/19	Anthem Blue Cross Blue Shield P.O. Box 110 Fond du Lac, WI 54936-0110
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
WageWorks (Retiree Medical Plan billing administrator)	**Customer Service:** 877.822.9091	PO Box 660212 Dallas, TX 75266-0212
Express Scripts — Prescription Plan	**Under Age 65 Customer Service:** 800.935.7189 **Over Age 65 Customer Service:** 866.838.3979	PO Box 2858 Clinton, IA 52733-2858

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 (1.800.633.4227). TTY users should call 1.877.486.2048.

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 1.800.772.1213 (TTY 1.800.325.0778).

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

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under federal law require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have questions or would like more information, please contact your medical plan provider. See page 13 for contact information.

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. The amounts are shown on the charts on pages 5 and 7. If you have questions or would like more information, please contact your medical plan provider. See page 13 for contact information.

Health Insurance Portability And Accountability Act of 1996 (HIPAA)

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

HIPAA notice of special enrollment rights

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

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

Special enrollment provisions

Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you had other group health plan coverage or other health insurance and you completed and submitted a Postponement Form* to the Benefits Office on your termination or retirement date, 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 31 days after you 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.

**You will not be allowed to enroll in the Plan at a later date if you did not complete a Postponement Form prior to your termination or retirement.*

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 your new dependents in the Plan. You must request enrollment within 31 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).

Alabama - Medicaid

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

Alaska - Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arkansas - Medicaid

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

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

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

Florida - Medicaid

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

Georgia – Medicaid

Website: http://dch.georgia.gov/medicaid – Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

Indiana - Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

Iowa - Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

Kansas - Medicaid

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

Kentucky - Medicaid

Website: https://chfs.ky.gov/agencies/dms/Pages/default.aspx
Phone: 1-800-635-2570

Louisiana - Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

Maine- Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

Massachusetts - Medicaid and CHIP

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

Minnesota - Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

Missouri - Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

Montana - Medicaid

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

Nebraska - Medicaid

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

Nevada - Medicaid

Medicaid Website: https://www.medicaid.nv.gov/
Medicaid Phone: 1-800-992-0900

New Hampshire - Medicaid

Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 1-603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

New Jersey - Medicaid and CHIP

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

New York - Medicaid

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

North Carolina - Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 1-919-855-4100

North Dakota - Medicaid

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

Oklahoma - Medicaid and CHIP

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

Oregon - Medicaid

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

Pennsylvania - Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

Rhode Island - Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347

South Carolina - Medicaid

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

South Dakota - Medicaid

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

Texas - Medicaid

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

Utah - Medicaid and CHIP

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

Vermont - Medicaid

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

Virginia - Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

Washington - Medicaid

Website: https://www.hca.wa.gov/health-care-services-supports/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

West Virginia - Medicaid

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

Wisconsin - Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

Wyoming - Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 1-307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

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

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