Health Benefits Plans
Summary Plan Description

(Effective: January 1, 2018)

DePaul University Medical Plan

DePaul University Dental Plan

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GENERAL INFORMATION

This summary plan description ("SPD") contains general information about the DePaul University Health Benefits Plans (including the Medical Plan, Dental Plan, and Vision Plan, collectively the "Health Plans"), which are offered under the DePaul University Health and Welfare Benefits Plan ("Plan"), sponsored by DePaul University ("DePaul"). This SPD includes information relating to:

- Who is eligible to participate in the Health Plans
- How to enroll in the Health Plans
- When you may change your coverage under the Health Plans
- When your coverage under the Health Plans ends
- How to file your claims for benefits
- How to appeal if your claim is denied
- Your privacy rights with respect to the Health Plans
- Your rights under federal law (including ERISA)
- Administrative information about the Health Plans
- Benefits available under the Health Plans

For the Health Plans, a "plan year" is January 1 to December 31. This SPD describes the Health Plans in effect as of January 1, 2018.

WHO IS ELIGIBLE

Covered Employee Classifications

Your eligibility for coverage under the Health Plans is based on your employee classification, as described below. Depending on your employee classification, you may be eligible for coverage under some or all of the benefit programs that make up the Health Plans.

Full-Time Employees

Employees who are classified as full-time are generally eligible to participate in all of the benefit programs offered under the Health Plans.

You are eligible to participate in the Health Plans as a full-time employee if you are in:

- an **active faculty position** that is classified as full-time, and you are under a contract or letter of appointment issued by the Office of the Provost; or
- an **active staff member position** that is classified as full-time, and you are regularly scheduled to work at least 1,820 hours per year.

Newly Hired Full-Time Employees

When you are hired into a full-time employee classification, you will be immediately eligible to enroll in the benefit programs under the Health Plans, in accordance with the procedures described in ***Initial Enrollment*** below.

Part-Time Employees

If they meet the conditions described below, employees who are classified as part-time are eligible to participate in the following benefits under the Health Plans:

- BlueEdge CDHP option under the Medical Plan,
- Dental Plan, and
- Vision Plan.

Newly Hired Part-Time Employees

When you are hired into a part-time employee classification, your eligibility will initially be determined based on the first 12 months in which you are employed by DePaul. The Office of Human Resources will review your hours of service during your initial 12 months of employment to determine if you meet the following requirements:

- For part-time faculty members, you are credited with the hours equivalent to a teaching load of at least six 4-credit hour courses (at least four courses for the Law School) during your initial 12 months of employment.
- For part-time staff members, you are credited with at least 1,000 hours of service during your initial 12 months of employment.

If you meet the applicable requirements, you will be eligible to enroll in the benefit programs under the Health Plans offered to part-time employees, in accordance with the procedures described in ***Initial Enrollment*** below.

Note:

If you are hired into a part-time position in which DePaul expects that you will work, on average, 30 or more hours each week, you may be eligible to participate in one or more of the benefit programs offered under the Health Plans. In the event that you fall into this classification, the Benefits Department will provide you with details related to your benefits eligibility.

Ongoing Part-Time Employees

In addition to the initial eligibility determination made based on your initial 12 months of employment, the Office of Human Resources reviews benefits eligibility for ongoing part-time faculty members and part-time staff members each October to determine eligibility for the following plan year. In order to be eligible for benefits in any plan year:

- For part-time faculty members, you must be credited with the hours equivalent to a teaching load of at least six 4-credit hour courses (at least four courses for the Law School) during the October 3 – October 2 timeframe immediately preceding the benefits eligible plan year.
- For part-time staff members, you must be credited with at least 1,000 hours of service during the October 3 – October 2 timeframe immediately preceding the benefits eligible plan year.

If you meet the applicable requirements, you will be eligible to enroll in the benefit programs under the Health Plans offered to part-time employees, in accordance with the procedures described in ***Annual Enrollment*** below.

In determining whether a newly hired or ongoing part-time employee has been credited with the required minimum hours, the following rules will apply:

- For part-time staff members, hours worked in all part-time positions will be taken into account.
- During a period of time in which a part-time staff member is employed by DePaul but is not actively working, hours are credited based on the average hours worked during the remainder of the measurement period.
- For part-time faculty members, for every contact hour an employee has in a given week, DePaul will credit an additional four hours of non-contact service.
- During a quarter in which a part-time faculty member is employed by DePaul but is not teaching, hours are credited based on the average hours worked during the quarters taught in the measurement period.

Voluntary Reduced Work Time Arrangements

Employees who transition to a voluntary reduced work time arrangement under DePaul's Voluntary Reduced Work Time Arrangement Policy remain eligible to participate in all of the benefit programs offered under the Health Plans.

Additional Covered Classifications

Grandfathered Group – Instructional Associates

The Office of Human Resources maintains a list of individuals in the grandfathered group that was previously classified as instructional associates. If you are in this grandfathered group, you will be notified of your eligibility to participate in one or more of the benefit programs offered under the Health Plans.

Members of Sponsoring Religious Order

Individuals who are members of DePaul's sponsoring religious order and who are directed by their ecclesiastical superior to provide services to DePaul are eligible to participate in all of the benefit programs offered under the Health Plans.

Trustees

Trustees of DePaul University (except Life Trustees) are eligible to participate in the PPO option offered under the Medical Plan.

Student Employees

If you are hired into a student employee classification, your eligibility will initially be determined based on the first 12 months in which you are employed by DePaul. The Office of Human Resources will review your hours of service during your initial 12 months of employment to determine if you are credited with at least 1,560 hours of service during your initial 12 months of employment. If you meet this requirement, you will be eligible to enroll in the BlueEdge CDHP option under the Medical Plan, at either the single coverage level or the single + children coverage level, for 12 months of coverage immediately following the determination of eligibility.

In addition to the initial eligibility determination made based on your initial 12 months of employment, the Office of Human Resources reviews benefits eligibility for ongoing student employees each October to determine eligibility for the following plan year. In order to be eligible for benefits in any plan year, you must be credited with at least 1,560 hours of service during the October 3 – October 2 timeframe immediately preceding the benefits eligible plan year. If you meet this requirement, you will be eligible to enroll in the BlueEdge CDHP option under the Medical Plan for coverage effective in the following plan year.

Temporary Employees

If you are a temporary full-time employee hired into a position that will last six months or less and that requires you to work at least 35 hours per week, you will be immediately eligible to enroll in the BlueEdge CDHP option offered under the Medical Plan, the Dental Plan and the Vision Plan, in accordance with the procedures described in ***Initial Enrollment*** below.

If you are a temporary part-time employee hired into a position that will last six months or less and that requires you to work less than 30 hours per week, your eligibility will initially be determined based on the hours of service you work in the first 12 months in which you are employed by DePaul. The Office of Human Resources will review your hours of service during your initial 12 months of employment to determine if you are credited with at least 1,000 hours of service during your initial 12 months of employment. If you meet this requirement, you will be eligible to enroll in the BlueEdge CDHP option under the Medical Plan, the Dental Plan and the Vision Plan, in accordance with the procedures described in ***Initial Enrollment*** below.

In addition to the initial eligibility determination made based on your initial 12 months of employment, the Office of Human Resources reviews benefits eligibility for ongoing temporary part-time employees each October to determine eligibility for the following plan year. In order to be eligible for benefits in any plan year, you must be credited with at least 1,000 hours of service during the October 3 – October 2 timeframe immediately preceding the benefits eligible plan year. If you meet this requirement, you will be eligible to enroll in the BlueEdge CDHP option under the Medical Plan, the Dental Plan and the Vision Plan, in accordance with the procedures described in ***Annual Enrollment*** below.

Throughout the SPD, references to "you," "your," "employee" and "covered person" generally include the individuals covered under these additional covered classifications.

Pre-65 Retirees

If you are a retiree and you have not yet turned 65, you may be eligible to participate in the PPO option or the HMO Illinois option under the Medical Plan. Eligibility requirements and other rules relating to pre-65 retirees are described in the ***Eligibility Rules for Retirees*** section below.

Note: Benefits for retirees age 65 and over are described in the separate summary plan description applicable to the DePaul University Medical Plan for Retirees Age 65 and Over ("Over-65 Retiree Plan").

Eligibility Exclusions

You are not eligible to participate in the Health Plans if you are:

- covered by a collective bargaining agreement;
- a member of the Midwest Province of the Congregation of the Mission;
- an employee who has a non-U.S. home country or non-U.S. permanent residence, and you are employed in a position that will require you to work in a non-U.S. location; or
- designated by DePaul to be an independent contractor (whether determined at a later date to be a common law employee or otherwise).

ELIGIBILITY RULES FOR YOUR SPOUSE OR YOUR SECOND DOMICILED ADULT

If you are eligible to elect coverage for yourself, you also may elect coverage for your eligible dependents. Your dependents become eligible for coverage when you do, provided you have enrolled for coverage and have supplied the appropriate documents validating dependency. Your eligible dependents include your Spouse, your Second Domiciled Adult ("SDA"), your children, and the children of your SDA. This section describes the eligibility rules for your Spouse or your SDA. Rules governing the eligibility of your children and the children of your SDA, if any, are described below in ***Eligibility Rules for Your Child or Your SDA's Child***.

Your Spouse

Your spouse is your legal spouse under federal law, including a spouse from whom you are separated under a legal separation decree.

Your Second Domiciled Adult

If you are eligible for coverage under the Health Plans, you have the option of enrolling either a Related SDA or an Unrelated SDA, in lieu of enrolling a spouse. Your SDA is eligible for coverage under all of the benefit programs offered under the Health Plans. You are limited to enrolling only one SDA, and you may enroll a spouse or SDA, but not both.

Your SDA may fall under one of two classifications: Related SDA or Unrelated SDA. The criteria for each of these classifications are explained below.

Related SDA

An adult member of your household is a Related SDA if he or she:

- is your relative including your parent, son, daughter, grandchild, great grandchild, grandparent, great grandparent, brother, sister, half-brother, half-sister, uncle, aunt, nephew, niece, mother-in-law, father-in-law, step-parent, or step-child;
- is at least 18 years of age prior to the effective date of the coverage;

- shares your principal residence, and has shared your principal residence for at least the 6 months immediately prior to the effective date of the coverage;
- does not have other group health insurance;
- is not eligible for Medicare or Medicaid; and
- is your qualifying child or qualifying relative.

Definition of Qualifying Child
An individual is your "qualifying child" if he or she:
- is a citizen or national of the United States, or a resident of the United States, Mexico or Canada;
- is your child, sibling, stepsibling, or a descendant of any such individual;
- as of the last day of the year, is under age 19, under age 24 if a full-time student, or any age if permanently and totally disabled;
- provides 50% or less of his or her own support for the year; and
- resides at your principal place of residence for more than six months of the year (excluding temporary absences, such as for school).

Definition of Qualifying Relative
An individual is your "qualifying relative" if he or she:
- is a citizen or national of the United States, or a resident of the United States, Mexico or Canada;
- is your child, a descendant of your child, your sibling, your stepsibling, your parent, an ancestor of your parent, your stepparent, your niece, your nephew, your aunt, your uncle, your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law, or a member of your household who lives with you for the full tax year;
- receives more than 50% of his or her support for the year from you; and
- is not a "qualifying child" of you or any other taxpayer for the year.

Unrelated SDA
An adult (same or opposite sex as you) member of your household is an Unrelated SDA if he or she:

- is not related to you in any way that would prohibit marriage;
- is not legally married to any person;
- is at least 18 years of age prior to the effective date of the coverage;
- has shared your principal place of residence for at least the 6 months immediately prior to the effective date of the coverage;
- has a close personal relationship with you (not a casual roommate or tenant) that you and the SDA intend to be permanent;
- shares with you a mutual obligation of support and responsibility for each other's welfare; and
- does not have other group health insurance.

Your Unrelated SDA also includes an individual with whom you have entered into a civil union in Illinois, or a civil union, registered domestic partnership, or equivalent relationship that is recognized under the applicable law of another state, as long as such relationship has not been dissolved under applicable law.

Additional Taxation of Benefits

Under federal law, if you enroll in health coverage on behalf of an Unrelated SDA who does not meet the criteria to be considered your tax dependent for health coverage purposes (as described below), DePaul is required to report as taxable income to you the value of the health coverage DePaul provides on behalf of the Unrelated SDA. In addition, you will need to pay your premium contributions for the Unrelated SDA on an after-tax basis. To be a tax dependent for health coverage purposes, an Unrelated SDA must be a citizen or national of the United States, or a resident of the United States, Mexico or Canada and must meet all of the following requirements:

- share your principal residence for the full tax year (except for temporary reasons such as vacation, military service, or education) as a member of your household;
- receive more than 50% of his or her annual financial support from you; and
- not be a qualifying child of you or any other taxpayer for the year.

Compliance with Federal Tax Rules

DePaul will comply with the federal tax rules as follows:

- Coverage for a Related SDA will automatically be on a tax-favored basis. You may make pre-tax contributions for coverage of your Related SDA and will not have to include the value of the coverage in your income;
- Coverage for an Unrelated SDA will automatically be on a taxable basis, unless you upload a completed *Declaration of Tax Status* when you complete your enrollment through myHR; and
- Tax status changes will be made on a prospective basis only.

If you enroll an Unrelated SDA who is not your tax dependent for health coverage purposes, DePaul will:

- Establish the fair market value of the health coverage;
- Include this amount (less any after-tax employee contributions) in your income when determining your income and payroll taxes and when completing your W-2; and
- Deduct the premium contributions you pay for the Unrelated SDA from your pay on an after-tax basis.

ELIGIBILITY RULES FOR YOUR CHILD OR YOUR SDA'S CHILD

This section describes the eligibility rules for your children and the children of your SDA. Rules governing the eligibility of your Spouse or your SDA are described above in ***Eligibility Rules for Your Spouse or Your Second Domiciled Adult***.

Your Children

Generally, a child includes your natural-born child, your adopted child (including a child who is placed permanently with you for adoption), your stepchild, and a child for whom you or your spouse are the court-appointed legal guardian.

Different eligibility requirements apply for your children to be covered under:

- the Medical Plan, and
- the Dental and Vision Plans

Eligibility Rules for Your Children under the Medical Plan

To be eligible for coverage under the Medical Plan, your child must be:

- under age 26;
- under age 30, if a military veteran residing in Illinois, who has received a release or discharge (other than a dishonorable discharge); or
- any age, if disabled.

Note about Dependent Coverage under the BlueEdge CDHP Option

You should carefully consider whether you want to enroll in the BlueEdge CDHP option if you want to cover a dependent child who is not a qualifying child or qualifying relative as those terms are defined for health coverage purposes under the Internal Revenue Code ("IRC"), or if you want to cover an Unrelated SDA who is not your qualifying relative as that term is defined for health coverage purposes under the IRC. Although you may enroll such a dependent in the BlueEdge CDHP option if he or she meets the Medical Plan eligibility requirements, you may be reimbursed from your Health Savings Account ("HSA") for medical expenses incurred on behalf of your dependent *only if*: (1) for a child, he or she is a qualifying child or qualifying relative, and (2) for an Unrelated SDA, he or she is your qualifying relative. This means that, depending on your specific circumstances, you could elect to enroll your child or Unrelated SDA in the BlueEdge CDHP option for purposes of the high deductible health plan portion, but find that you are unable to be reimbursed from your HSA for medical expenses attributable to that dependent's treatment. As an example, if you elect coverage under the BlueEdge CDHP for a dependent child who is over age 19 and is neither a full-time student nor totally and permanently disabled, you will not be able to use money in your HSA for the child's medical expenses, unless the child meets the requirements to be a qualifying relative as defined below.

Eligibility Rules for Your Children under the Dental Plan and Vision Plan

To be eligible for coverage under the Dental Plan and the Vision Plan, your child must be:

- unmarried;
- either:
  - under age 23, or
  - any age, if disabled; and
- considered a tax dependent for health coverage purposes under the IRC.

Children of Your Second Domiciled Adult

If your SDA is enrolled for coverage under the Health Plans, you may have the option to enroll your SDA's children in the Health Plans as well. Generally, a child includes your SDA's natural-born child, adopted child (including a child who is placed permanently for adoption), stepchild, and a child for whom your SDA is the court-appointed legal guardian.

Eligibility Rules for Your Unrelated SDA's Children under the Medical Plan

Your Unrelated SDA's child is eligible to participate in the Medical Plan if he or she is:

- under age 26;
- under age 30, if a military veteran residing in Illinois, who has received a release or discharge (other than a dishonorable discharge); or
- any age, if disabled.

Eligibility Rules for Your Related SDA's Children under the Medical Plan

Your Related SDA's child is eligible to participate in the Medical Plan if he or she:

- is unmarried;
- is either:
  - under age 26,
  - under age 30, if a military veteran residing in Illinois, who has received a release or discharge (other than a dishonorable discharge), or
  - any age, if disabled;
- resides at your principal place of residence for at least six months of the year (excluding temporary absences, such as for school); and
- receives more than 50% of his or her annual financial support from either you or your SDA.

Eligibility Rules for Your SDA's Children under the Dental Plan and Vision Plan

To be eligible for coverage under the Dental Plan and the Vision Plan, your SDA's child must be:

- unmarried;
- either:
  - under age 23, or
  - any age, if disabled; and
- considered a tax dependent for health coverage purposes under the IRC.

Health Plans Coverage for a Disabled Child

If you cover a dependent child who is disabled, he or she may continue to be covered under the Health Plans, after reaching the maximum age requirement, as long as your own Health Plans coverage continues and the child meets the following conditions:

- the disability began before the child reached the maximum age limit for coverage;
- the child is deemed permanently and totally disabled;
- the child is unmarried; and
- the child is your qualifying child or qualifying relative as defined below. See ***Additional Taxation of Benefits***.

A child will be deemed permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, as determined by the medical claims administrator.

The Plan Administrator may request proof of a child's disability from time to time. This proof will not be requested any sooner than two months before the child's coverage would normally end. If proof is requested and it is not received within 60 days, the child's coverage will end, whether or not a disability exists. See ***Continuing Your Coverage After You Leave DePaul***.

If you are a new hire, and you covered a disabled child under your previous group health coverage, but the child is beyond the maximum age limit for coverage under the Health Plans, you may enroll the child in Health Plans coverage, subject to providing proof of disability and proof that the child was covered in a group health plan immediately prior to your employment at DePaul.

Special Note for Vision Service Plan Participants

To continue coverage for a disabled child under the Vision Plan, you may be required to provide proof of the child's disability within 31 days of (1) the date the child's coverage would otherwise end, or (2) a request from VSP to provide proof of continued disability (in no event, however, will you be required to provide such proof more frequently than on an annual basis).

Health Plans Coverage for Children Under a Qualified Medical Child Support Order (QMCSO)

Federal law requires group health plans to honor QMCSOs. In general, QMCSOs are orders from a state court or state administrative agency requiring you to provide medical support to a child, for example, in cases of legal separation or divorce. In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which does the following:

- Specifies your name and last known address, and the child's name and last known address;
- Provides a reasonable description of the type of coverage to be provided by the Health Plans, or the manner in which the type of coverage is to be determined;
- States the period to which it applies; and
- Specifies each plan to which it applies.

The QMCSO may not require the Health Plans to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the Health Plans. Upon approval of a QMCSO the plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order, to the extent it is consistent with the terms of the Health Plans. A child's coverage under a QMCSO will take effect on the later of the date provided in the QMCSO, or the first day of the month following the date the Plan Administrator approves the QMCSO.

At your request, the Plan Administrator will furnish QMCSO procedures that describe the process to follow when entering a QMCSO.

Additional Taxation of Benefits

Under federal law, if you enroll in health coverage on behalf of a child (either your child, or your SDA's child) who does not meet the criteria to be considered your tax dependent for health coverage purposes, DePaul is required to report the value of the health coverage DePaul provides as taxable income to you. In addition, you will need to pay your premium contributions for the individual on an after-tax basis.

Definition of Tax Dependent for Health Coverage Purposes under the IRC

To be a tax dependent for health coverage purposes, the child must be a citizen or national of the United States, or a resident of the United States, Mexico or Canada.

If the child is your natural-born child, stepchild, legally adopted child (including a child placed with you for adoption), or eligible foster child, he or she is a tax dependent for health coverage purposes through the end of the year in which he or she turns age 26. If the child does not fit within any of these categories, he or she is a tax dependent for health coverage purposes only if he or she is a qualifying child or qualifying relative as defined below.

Qualifying Child

Your child is your qualifying child if he or she:

- is your child, sibling, stepsibling, or a descendant of any such individual;
- as of the last day of the year, is under age 19, under age 24 if a full-time student, or any age if permanently and totally disabled;
- provides 50% or less of his or her own support for the year; and
- resides at your principal place of residence for more than six months of the year (excluding temporary absences, such as for school).

Qualifying Relative

Your child is your qualifying relative if he or she:

- is your child, a descendant of your child, your sibling, your stepsibling, your niece, your nephew, your father, your mother, your aunt, your uncle, brother-in-law or sister-in-law, or a member of your household who lives with you for the full tax year;
- receives more than 50% of his or her support from you; and
- is not your or anyone else's qualifying child dependent.

Your SDA's child is your qualifying relative if he or she:

- is a member of your household;
- shares your principal residence for the full tax year (excluding temporary absences, such as for school);
- receives more than 50% of his or her support from you; and
- is not anyone else's qualifying child dependent.

Compliance with Federal Tax Rules

DePaul will comply with the federal tax rules as follows:

- Coverage for a child who is not your tax dependent for health coverage purposes will automatically be on a taxable basis unless you upload a completed *Declaration of Tax Status* form when you complete your enrollment through myHR; and
- Tax status changes will be made on a prospective basis only.

If you enroll a child who is not your tax dependent for health coverage purposes, DePaul will:

- Establish the fair market value of the health coverage;
- Include this amount (less any after-tax employee contributions) in your income when determining your income and payroll taxes and when completing your W-2; and
- Deduct the premium contributions you pay for the child from your pay on an after-tax basis.

Requirement to Notify DePaul if Your Dependents' Eligibility Changes

If your dependent who is enrolled in the Health Plans ceases to satisfy the eligibility requirements as described above, you must notify DePaul within 31 days following the event.

Important Note Regarding Ineligible Dependents

If you cover a dependent who is, in fact, not eligible for coverage under the Health Plans, you will be responsible for reimbursing claims paid by the Health Plans on behalf of the dependent, for the time the dependent was not an eligible dependent. Further, you may be subject to back taxes and IRS penalties.

You are strongly advised to seek the advice of tax counsel if you have any questions related to the tax status of a dependent.

ELIGIBILITY RULES FOR RETIREES

Pre-65 Retirees

If you are a retiree and you have not yet turned 65, you may be eligible to participate in the following benefit options:

- PPO option under the Medical Plan, and
- HMO Illinois option under the Medical Plan.

In order to be eligible to participate in these benefit options, you must satisfy the following criteria at the time of your retirement:

- you are enrolled in coverage under the Medical Plan under one of the following classifications:
  - full-time employee (if you are in a voluntary reduced work time arrangement, you are considered a "full-time employee" for the purpose of determining eligibility for pre-65 retiree coverage); or
  - member of DePaul's sponsoring religious order; and
- you meet one of the following age and service requirements:
  - you are at least age 55, and you have accumulated at least 20 years of full-time service; or
  - you are at least age 62, and you have accumulated at least 10 years of full-time service.

As a pre-65 retiree, you are not eligible to participate in the CDHP option under the Medical Plan, nor are you eligible for coverage under the Dental Plan or the Vision Plan.

If you are eligible to participate in the PPO option and the HMO Illinois option under the Medical Plan as a pre-65 retiree, DePaul will notify you and will explain the steps that you should take to enroll in pre-65 Medical Plan coverage.

Excluded Classifications

In addition to the general exclusions listed above in ***Eligibility Exclusions***, individuals in the following classifications are not eligible for pre-65 retiree coverage:

- Grandfathered Group Previously Classified as Instructional Associates
- Part-Time Employees
- Student Employees
- Trustees
- Temporary Employees

Dependents of Pre-65 Retirees

If you are eligible to participate in the Medical Plan as a pre-65 retiree, you may also elect to continue coverage for your eligible dependents under the PPO option or the HMO Illinois option of the Medical Plan. Your dependents will not be eligible to participate in the CDHP option under the Medical Plan, the Dental Plan or the Vision Plan.

Special Rule for Related SDA Eligibility

You may elect coverage for your Related SDA who has not attained age 65 and become eligible for Medicare, or for your Related SDA's child, *only if* your Related SDA is already enrolled in Medical Plan coverage as your Related SDA at the time of your retirement. If your Related SDA is not enrolled in the Medical Plan at the time of your retirement, you may not add him or her after you have retired. Additionally, if you drop coverage for your Related SDA at any point while you are covered under the Medical Plan as a pre-65 retiree, you may not re-enroll that Related SDA, or elect to cover a different Related SDA, at any point in the future.

Election Changes for Pre-65 Retiree Coverage

If you are covered under the Medical Plan as a pre-65 retiree, you are generally permitted to change your elections under the same circumstances that permit election changes for active employees. See ***Changing Your Coverage*** for more details.

However, you may not add a Related SDA or a Related SDA's child once you are covered as a pre-65 retiree. If your Related SDA or Related SDA's child is not covered under the Medical Plan at the time of your retirement, then he or she may not be added once you are covered as a pre-65 retiree.

When Your Coverage Ends

If you are covered under the Medical Plan as a pre-65 retiree, your Medical Plan coverage will end on the last day of the month in which any of the following occur:

- you lose eligibility for Medical Plan benefits (including when you are no longer eligible to participate in the Medical Plan due to your eligibility for Medicare upon reaching age 65 – you will lose eligibility as of the last day of the month prior to the month in which you are eligible to enroll in Medicare);
- you become eligible for Medical Plan benefits as an active employee of DePaul;
- the Medical Plan is terminated;
- pre-65 retirees are no longer eligible for coverage under the Medical Plan; or
- you stop making the contributions needed to pay for your coverage.

How Your Medicare Eligibility Affects Your Coverage

Your coverage as a pre-65 retiree will terminate when you become eligible for health care coverage under Medicare. You generally become eligible for Medicare coverage beginning with the month in which you turn age 65. Therefore, in most cases your last day of Medical Plan coverage as a pre-65 retiree will be the last day of the month prior to the month in which you turn age 65, and your Medical Plan coverage as a pre-65 retiree will end regardless of whether you choose to enroll in Medicare. DePaul will notify you prior to the termination of your pre-65 retiree coverage and will explain the steps you need to take to complete enrollment in the Over-65 Retiree Plan.

You may also choose to drop Medical Plan coverage at any point prior to becoming eligible for Medicare benefits. If you drop your coverage, you will not be eligible to rejoin the Medical Plan or the Over-65 Retiree Plan at a later date, under any circumstances.

Effect of Your Medicare Eligibility on Your Dependents' Coverage

Any of your dependents who are covered under the Health Plans at the time your coverage terminates due to Medicare eligibility, may continue coverage in the PPO option or the HMO Illinois option under the Medical Plan, provided that you elect to participate in the Over-65 Retiree Plan.

If You Return to Work at DePaul After You Have Retired

After you retire, if you return to work at DePaul at a later date, your eligibility for retiree coverage from DePaul (under either the Medical Plan or the Over-65 Retiree Plan) may end.

If you are enrolled in the Medical Plan as a pre-65 Retiree and you return to work, in a part-time or full-time position, in which you are eligible for Medical Plan benefits as an active employee (see ***Who is Eligible - Covered Employee Classifications*** above), you will no longer be eligible to participate in the Medical Plan as a pre-65 Retiree, but you will be eligible for Health Plans coverage as an employee. If you return to work in a full-time position, when you subsequently retire you will again be eligible under the Medical Plan as a pre-65 Retiree if you have not attained age 65, or under the Over-65 Retiree Plan if you meet the eligibility requirements, based on your initial date of hire with DePaul and your most recent date of retirement. If you return to work in a part-time position, when you subsequently retire, you will not be eligible to reenroll under the Medical Plan as a pre-65 Retiree, or under the Over-65 Retiree Plan.

Exception for Retirees Rejoining the Active Medical Plan on January 1, 2015

There is an exception to the above rule. If you are an active part-time employee and eligible for part-time benefits under the Medical Plan beginning January 1, 2015, and you were enrolled in retiree coverage under the Medical Plan or the Over-65 Retiree Plan as of December 31, 2014, when you subsequently retire or lose eligibility for Medical Plan benefits as an employee, you will be eligible at that time to reenroll in retiree coverage under the Medical Plan or under the Over-65 Retiree Plan, as applicable, based on your initial date of hire with DePaul and your most recent date of retirement. However, if you later drop your retiree medical coverage with DePaul again, for any reason, including because you again become eligible for benefits as an active employee, you will not be eligible to rejoin the Medical Plan or the Over-65 Retiree Plan at a later date, under any circumstances.

When Your Dependents' Coverage Ends

When you are covered under the Medical Plan as a pre-65 retiree, your dependents' Medical Plan coverage will end on the earliest of the following:

- in the case of your spouse, Unrelated SDA or dependent child (not including a child of your Related SDA), the date your coverage ends, other than due to:
  - your attainment of age 65 if you transfer into the Over-65 Retiree Plan at that time, or
  - your death;
- in the case of your Related SDA or a child of your Related SDA, the date your coverage ends, other than due to your attainment of age 65 if you transfer into the Over-65 Retiree Plan at that time;
- in the case of your spouse or SDA, the date he or she no longer qualifies as an eligible dependent;
- in the case of a dependent child (including a child of your SDA), the last day of the month in which he or she no longer qualifies as an eligible dependent; or
- in the case of a child of your SDA, the date the SDA is no longer eligible for coverage.

How Medicare Eligibility Affects Your Dependents' Coverage

If Your Spouse or Unrelated SDA Becomes Eligible for Medicare

When you are covered under the Medical Plan as a pre-65 retiree, if your spouse or Unrelated SDA is enrolled as your dependent under the Medical Plan, his or her coverage will end on the last day of the month prior to the month in which he or she becomes eligible to enroll in Medicare as the result of reaching age 65, regardless of whether your spouse or Unrelated SDA actually enrolls in Medicare. At this point, you may elect to cover your spouse or Unrelated SDA under the Over-65 Retiree Plan, even if you are not yet eligible to enroll in the Over-65 Retiree Plan.

If Your Related SDA Becomes Eligible for Medicare

When you are covered under the Medical Plan as a pre-65 retiree, if your Related SDA is enrolled as your dependent under the Medical Plan, his or her coverage will end on the last day of the month prior to the month in which he or she becomes eligible to enroll in Medicare as the result of reaching age 65, regardless of whether he or she actually enrolls in Medicare. Your Related SDA is not eligible to participate in the Over-65 Retiree Plan.

If You Become Eligible for Medicare – Effect on Dependent Children

When you are covered under the Medical Plan as a pre-65 retiree, if your dependent child is enrolled as your dependent under the Medical Plan, he or she will continue to be eligible for coverage in the PPO option or the HMO Illinois option after you turn age 65, as long as you enroll in the Over-65 Retiree Plan. Your dependent child's Medical Plan coverage will end as described above.

If your SDA's child is enrolled as your dependent under the Medical Plan, he or she will continue to be eligible for coverage in the PPO option or the HMO Illinois option after you turn age 65, as long as (1) you enroll in the Over-65 Retiree Plan and (2) your SDA remains covered under the Medical Plan. Your Related SDA's child's Medical Plan coverage will end as described above. (See ***When Your Dependents' Coverage Ends***)

JOINING THE HEALTH PLANS

There are three different circumstances under which you may enroll yourself and your eligible dependents in the Health Plans. You may enroll:

- When you are first hired (Full-Time Employee Classifications), or first eligible (Part-Time Employee Classifications; Additional Covered Classifications),
- During annual open enrollment, or
- When you experience a qualified change event. (See ***Changing Your Coverage***)

When you enroll in the Health Plans, you choose your coverage options under each of the Medical Plan, Dental Plan, and Vision Plan. You begin by selecting your benefit option from each of the three programs. Then you select the dependents you wish to cover (if any) under each of the Health Plans. You must enroll yourself in a given program before you can enroll a dependent or select family coverage. The number and types of dependents you choose to cover will determine your coverage category in each program. The coverage categories that may be offered to you, depending on your classification, are:

- Single
- Single + Spouse
- Single + Children
- Family

Once you enroll, you cannot make changes during the year unless you have a qualified change event.

INITIAL ENROLLMENT

Full-Time Faculty and Staff

If you are a new full-time faculty member starting in the fall, you must enroll in the Health Plans online through myHr within 31 days of September 1st. Coverage for new full-time faculty members starting in the fall will be effective on September 1st.

If you are a full-time faculty member and your job begins during the academic year already in progress, or if you are a full-time staff member (including a temporary full-time employee), then you must enroll in the Health Plans online through myHR within 31 days of your date of hire. Your coverage will be effective on the first day of the month following your date of hire (or on the actual date of hire if you are hired on the 1st of the month), provided you complete all the enrollment requirements.

> *Example:* Jane, a full-time employee, starts working for DePaul on September 15. She must enroll in her benefits on myHR by October 16 (31 days). Her benefits and payroll deductions become effective retroactive to October 1.

If you do not enroll during your initial enrollment period, you will be automatically enrolled in the Medical Plan CDHP option for employee-only coverage, and pre-tax deductions for the cost of this coverage will be taken from your paychecks. You will not be enrolled in coverage under the Dental Plan or Vision Plan. If you do not wish to enroll in a medical option offered by DePaul, you must elect to "Waive" coverage during your initial enrollment period.

Part-Time Faculty and Staff

You will be notified of your eligibility to participate in benefits once you meet the **Part-Time Employee Classification** requirements described in the ***Covered Employee Classifications*** section (including the requirements to be benefits-eligible as a temporary part-time employee). You will have 31 days from the date of your notification to enroll in benefits online through myHR.

- If your notification relates to a determination of initial eligibility (i.e., based on hours of service credited during your initial 12 months of employment), your election will be effective for the 12-month period immediately following the determination.
- If your notification relates to a determination of eligibility based on the annual determination period (October 3 – October 2), your election will be effective for the following calendar year, January 1 through December 31.

If you do not enroll within 31 days of your notification, your coverage under the Health Plans will be waived. Your next opportunity to enroll will be the next annual enrollment period (unless you experience a qualified change event that allows you to change coverage, as described in ***Changing Your Coverage***), provided you continue to meet the **Part-Time Employee Classification** requirements for benefits eligibility, as determined on an annual basis.

Voluntary Reduced Work Time Arrangements

If you transition to a voluntary reduced work time arrangement under DePaul's Voluntary Reduced Work Time Arrangement Policy, you will remain enrolled in the Health Plans through December 31 of the same year. You may be able to change your coverage elections (see ***Changing Your Coverage***). Provided you remain employed in your position, you will be eligible to participate in annual enrollment in the fall to elect coverage for the upcoming calendar year.

Members of Sponsoring Religious Order

If you are a member of DePaul's sponsoring religious order who has been directed by your ecclesiastical superior to provide services to DePaul, you must enroll in the Health Plans online through myHR within 31 days of your initial eligibility for benefits. Your coverage will be effective on the first day of the month following the date of your initial eligibility (or on the actual date of initial eligibility if that date is the 1st of the month), provided you complete all the enrollment requirements. Provided you remain in your position, you will then be eligible to participate in annual enrollment in the fall to elect coverage for the upcoming calendar year.

Dependents

Spouses and Children

Before you can enroll a spouse or dependent child on your health coverage, you must complete and submit a *Dependent Add/Change* form. If you enroll a dependent in one of the following categories, you must also complete a *Declaration of Tax Status* form:

- Second Domiciled Adult,
- Child of your SDA, or
- Child for whom you or your spouse has legal guardianship.

Forms are available on the Human Resources website at http://offices.depaul.edu/human-resources or may be obtained from the Benefits Department.

Once you have completed and submitted a *Dependent Add/Change* form, you will be able to complete enrollment of your spouse and/or dependent child (not including a child of your SDA) online through myHR.

If you elect to cover eligible dependents, coverage for your dependent(s) whom you enroll when you are first eligible begins on the same day as your coverage begins.

Second Domiciled Adults and Children of SDAs

You may elect coverage for an SDA, and your SDA's eligible child, during open enrollment or within 31 days of one of the following events:

- You and your SDA first meet all of the eligibility requirements; or
- Your SDA loses other group coverage due to change in employment, work site or income.

To Enroll an SDA

To enroll an SDA, or an SDA's child, you must first download the Second Domiciled Adult Affidavit of Eligibility and Declaration of Tax Status forms from the Human Resources website at http://offices.depaul.edu/human-resources. Once you have completed the *Second Domiciled Adult Affidavit of Eligibility* and Declaration of Tax Status forms, and uploaded them to myHR, you will be able to enroll your SDA and your SDA's children.

Required Documentation

In addition to the *Second Domiciled Adult Affidavit of Eligibility*, to enroll an SDA or an SDA's child, you must complete and return a *Declaration of Tax Status* form and any additional required documentation within 31 days of electing coverage for your SDA or your SDA's child. If you fail to provide the required documents, you will not be allowed to enroll your SDA or your SDA's child until the next annual enrollment period, except as noted above or in ***Changing Your Coverage***. You only need to complete the forms once, at initial enrollment.

If your SDA's or SDA's child's tax status changes, you must file a new *Declaration of Tax Status* form. Tax status changes will be made on a prospective basis only. Forms are available on the Human Resources website at http://offices.depaul.edu/human-resources or may be obtained from the Benefits Department.

ANNUAL ENROLLMENT

Each fall, DePaul will offer an annual enrollment period, during which you will have the opportunity to re-enroll in the Health Plans for the next calendar year (your new coverage will start on January 1), provided you remain eligible to participate in the Health Plans. DePaul will notify eligible employees of the enrollment period and annual enrollment deadline, along with instructions on how to complete the online enrollment through myHR. Information about annual enrollment is available on the Human Resources website at https//hr.depaul.edu or may be obtained from the Benefits Department.

If You Do Not Re-Enroll

Changes will not be allowed after the annual enrollment deadline, unless you experience a qualified change event that permits you to change your elections, as described below. If you remain eligible under the Health Plans and do not re-enroll online through myHR during the annual enrollment period, you will continue to have the same level of coverage and benefit options under the Health Plans that you chose the year before. There is an exception to this rule if you have a Flexible Spending Account (see the separate SPD for the DePaul University Flexible Spending Account Program for more information) or a Health Savings Account (see ***BlueEdge CDHP*** for more information), for which you must re-enroll each year.

CHANGING YOUR COVERAGE

Once you enroll in or waive coverage under the Health Plans, you generally cannot change your elections until the following annual enrollment period. However, there are certain circumstances described below, when you may be eligible to change your elections outside of the annual enrollment period.

If you experience a qualified change event that allows you to change your elections outside of the annual enrollment period, you can complete the process online through Campus Connect. To begin the process, log into myHR and go to Main Menu → Self Service → Benefits → Life Events, select your event type, and provide the effective date of the election change. Once you confirm the effective date, you will have the opportunity to update dependent information and/or to add a new dependent. You then will be prompted to upload all required supporting documentation, which must be reviewed and approved by the Benefits Department before you can complete your election change. When you receive e-mail

confirmation that your supporting documentation has been approved, you will need to return to your open Life Event in myHR, click "Start My Enrollment," select the election change event which has been approved, and follow the steps to update your Health Plans elections. Once you have made all of your election changes and confirmed your election changes, you must click "Event Completion and Exit," then "Complete" to finalize your election change. Your election change will not be complete until you finalize your choices.

You must make your election changes within the time periods described below for each type of qualified change event. If you do not request to change your coverage elections within the required time period, you will not be allowed to change your coverage until the next annual enrollment period (unless you experience another qualified change event).

You may change your coverage elections and coverage elections for your dependents mid-plan year only if the changes result from, and are consistent with, any of the following qualified change events:

- *HIPAA special enrollment*
- *Qualified change in status*
- *Significant cost or coverage change*
- *Medicare or Medicaid entitlement*
- *Qualified medical child support order (QMSCO)*

Your election change, and the corresponding salary deduction change, will be effective as of the later of (1) the date on which you complete the election change process through myHR, or (2) the date of the qualified change event. You will have 31 days following the date of the qualified change event to complete the election change process, including providing any required supporting documentation.

Special Enrollment Rules

Under the Health Insurance Portability and Accountability Act (HIPAA), you are allowed to enroll yourself and your eligible dependents outside of the annual enrollment period when certain events occur. Special enrollment rights exist when:

- You acquire a new dependent due to marriage, birth, adoption or placement for adoption;
- You declined coverage under the Health Plans during a previous enrollment period because you were covered under another group health plan (or group health insurance), but you subsequently lose your other coverage for any of the following reasons:
  - You or your dependents exhaust COBRA continuation coverage under another employer's group health plan (other than due to failure to pay contributions or for cause);
  - Employer contributions toward the other group health plan coverage terminate; or
  - You or your dependents lose eligibility under the other group health plan or health insurance coverage (other than due to your failure to pay contributions or for cause), including:
    - As a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment;
    - In the case of an individual HMO policy, loss of coverage because you no longer reside or work in the service area;
    - In the case of a group HMO, loss of coverage because you no longer reside or work in the service area, provided that no other benefit package is available to you
    - You or your dependent incurs a claim that meets or exceeds a lifetime limit on all benefits; or
    - Your current employer decides to stop contributing for your coverage.
  - You or your dependent becomes:
    - ineligible for coverage under a Medicaid plan or a state child health plan, and as a result coverage is terminated; or
    - eligible for a premium assistance subsidy for the Medical Plan under Medicaid or the state child health plan.

When your special enrollment right results from the fact that you acquire a new spouse or dependent through marriage, birth or adoption, you can enroll your new spouse or dependent in the Health Plans. In addition, if you are not already enrolled in the Health Plans, you can enroll yourself during the special

enrollment period. If your spouse is not already enrolled in the Health Plans and you have special enrollment rights because you acquire a new dependent, you can enroll your spouse during the special enrollment period. However, you cannot enroll any other dependents who were already eligible for benefits but not previously enrolled in the Health Plans.

The request for a change in coverage must be made through myHR within 31 days of the special enrollment event, unless the special enrollment event is you or your dependent becoming ineligible for coverage under a Medicaid plan or a state child health plan, or you or your dependent becoming eligible for a premium assistance subsidy for the plan under Medicaid or the state child health plan. For this special enrollment event, the request for a change in coverage must be made through myHR within 60 days of the date you lose coverage or become eligible for coverage, as applicable.

Change in Status Event

You may make a change to your coverage elections when certain change in status events occur, but only if the change is consistent with the event. The coverage change must be on account of and correspond to a change in status event that affects your or your dependent's eligibility for coverage under the Health Plans or another employer's plan, including a change in status event that results in an increase or decrease in the number of your dependents who may benefit from coverage.

The request for a change in coverage must be made within 31 days of the change in status event. The Benefits Department will review the situation to determine if a change in status event has occurred and if the requested election change is consistent with the change in status event.

The following are change in status events:

- *Number of dependents*—you gain or lose a dependent (birth, adoption, placement for adoption, death);
- *Marital status*—your marital status changes (marriage, divorce, legal separation, annulment, death of a spouse);
- *Employment status*—change in your employment status, or the employment status of your spouse or dependent, including: termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence and a change in worksite or other change in employment that affects eligibility under a health plan;
- *Dependent satisfies or ceases to satisfy eligibility requirements*—your dependent becomes eligible or ceases to be eligible on account of age, student status or any similar circumstance, in this plan or under another plan; and
- *Residence*—a change in place of residence for you, your spouse, or your dependent.

Significant Cost or Coverage Change

You may also change your coverage elections outside of the annual enrollment period if:

- Coverage under the Health Plans is significantly reduced or ends (if the significant reduction results in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, or if no similar option is available, drop coverage; if the significant reduction does not result in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, but you may not drop coverage completely);
- The cost of a benefit option significantly increases (you may elect to pay the increased cost for your current option, select a new benefit option, or revoke your coverage if there is no similar option);
- The cost of a benefit option significantly decreases (you may select that option);
- A similar benefit option is added, significantly improved or eliminated, and you are eligible to elect the new or improved option; or
- There are significant changes under your spouse's or Unrelated SDA's plan due to a mid-year election change that satisfies the IRC regulations, or a change during an open enrollment period where your spouse's or Unrelated SDA's plan has a different plan year or enrollment period than the Health Plans.

Medicare or Medicaid Entitlement

If you or your spouse or dependent enroll in or lose coverage under Medicare (Part A or B) or Medicaid, you may change your medical coverage election under the Health Plans accordingly.

Qualified Medical Child Support Orders

Federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are orders from a state court or state administrative agency requiring an individual to provide medical support to a child, for example, in cases of legal separation or divorce. You may obtain a copy of the Health Plans' QMSCO procedures, without charge, by contacting the Plan Administrator.

Note: You may cancel coverage for a child pursuant to a QMSCO to enroll the child in another employer's plan, *only if* the child is actually enrolled in the other plan.

PLAN FUNDING AND PAYING FOR YOUR HEALTH PLANS COVERAGE

Except for the HMO Illinois option and the Vision Plan, the Health Plans are self-insured, which means claims are paid from the contributions Health Plans participants make and from the general assets of DePaul. Your cost for coverage depends on the benefit options you choose and the eligible dependents you choose to cover.

How Contribution Rates are Determined

Each benefit option has an associated rate, which is the amount the benefit costs you. The rates for each benefit option are posted on the Human Resources website at https://hr.depaul.edu.

In general, rates are based on these factors:

- how much it costs DePaul to provide that coverage;
- how many people are covered; and
- your benefit election.

In most cases, rates will not change in the middle of a year, even if the cost of providing coverage changes. However, if the cost for coverage increases or decreases during the year, DePaul reserves the right to make a corresponding change to the rate for that coverage. Also, if there is a mid-year cost increase for any Health Plans coverage that is significant, you will be allowed to make a change to your coverage option for the rest of the year. See ***Changing Your Coverage***.

Rates may change from one year to the next if DePaul's cost of providing that coverage changes. If benefit costs increase in future years, benefit rates also will increase. You will be notified of changes in the cost of coverage before you enroll for the next year.

How You Pay for Benefits

Generally, you pay for the cost of your coverage on a pre-tax basis over the calendar year, through regular deductions from your paycheck. Deductions generally will begin with the first paycheck you receive after you have completed your online enrollment, and the amount of your contribution will be taken out of each of your paychecks before taxes are calculated. That means that you are not taxed on these amounts. Because pre-tax dollars are not subject to Social Security Taxes, your future Social Security benefits may be slightly reduced if your earnings are less than the Social Security wage base.

The noted exception to this general rule is if you choose to cover an individual who does not meet the definition of a tax dependent for health coverage purposes under the IRC. In this case, your contributions will still be deducted from your regular paychecks over the calendar year, but the amount of your contribution will be taken out of each of your paychecks after taxes are calculated. In addition, DePaul

will include in your reportable income the value of any health care coverage it provides under the Health Plans to any such individual. See ***Additional Taxation of Benefits***.

Premium Credit for Participation in Wellness Initiatives

If you are an employee or former employee covered under the Medical Plan, you may qualify to receive a credit towards the cost of Medical Plan coverage if you participate in certain wellness initiatives offered by DePaul. The amount of the credit and the participation requirements will be determined prior to each plan year. DePaul is committed to helping you achieve your best health. If you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Benefits Department for more information about the wellness initiatives and reasonable alternative standards that may be available, or visit http://hr.depaul.edu/Benefits/Healthy_Vincents/index.html for more information.

EMPLOYMENT EVENTS AND EFFECT ON COVERAGE

In general, these are the rules that apply when certain employment events occur that may affect your coverage under the Health Plans.

If You Are on a Leave of Absence

There are five types of leave of absence that can be paid or unpaid:

- Disability Leave
- Personal Leave
- Faculty Research Leave
- FMLA Leave
- Military Leave

When you take a leave of absence (paid or unpaid), you will receive a letter describing the terms of your leave, including specific information about how the leave will affect your eligibility for benefits. The general rules that apply during a leave of absence are described below.

You may elect to discontinue participation in the Medical Plan, Dental Plan and/or Vision Plan during your leave of absence. In order to discontinue participation in one or more benefit options under the Health Plans during your leave, you must elect to do so within 31 days of the commencement of the leave. If you elect to discontinue participation in one or more benefit options, your last day of coverage will be the last day of the month in which you begin your leave of absence. If you do not elect to discontinue participation during your leave of absence, the rules set forth below will apply.

Employees on Paid Faculty Research Leave

If you are on a paid Faculty Research Leave, your coverage elections will remain in effect, and you will continue to have contributions deducted from your paychecks, throughout the duration of your leave.

Employees on Disability Leave

If you are on a Disability Leave (which may run concurrently with FMLA Leave) because you become disabled while you are employed by DePaul, you may be eligible to receive short-term disability benefits and/or long-term disability benefits. Refer to the separate "Sick Pay, Short and Long-Term Disability" Policy and the separate summary plan description for the DePaul University Insured Component Program for more information on available disability benefits.

Health Plans Coverage While You Are Receiving Short-Term Disability Benefits

You will continue to be eligible for coverage under the Health Plans while you are receiving short-term disability benefits. However, if you have fewer than five (5) years of accumulated full-time service with DePaul at the time your disability begins, your coverage under the Health Plans will terminate when your short-term disability benefits end (generally up to 6 months). Your coverage under the Health Plans will

also terminate in the event that you no longer qualify to receive short term disability benefits, but you do not return to work.

Medical Plan Coverage While You Are Receiving Long-Term Disability Benefits
If you qualify to receive long-term disability benefits (after your short-term disability benefits end) and you have at least five (5) years of accumulated full-time service with DePaul at the time your long-term disability benefits begin, you will continue to be eligible for coverage under the Medical Plan while you are receiving long-term disability benefits, provided that:

- you continue to pay the applicable premiums for coverage; and
- you apply for Medicare benefits within two years of becoming disabled.

Your eligibility for coverage under the Medical Plan will terminate when you terminate employment with DePaul, or when your long-term disability benefits end if you do not return to work. Note that you are not eligible to participate in any benefit options other than the Medical Plan while you are receiving long-term disability benefits, e.g., you are not eligible for coverage under the Dental Plan or the Vision Plan.

Employees on Military Leave
If you are on either a paid or an unpaid Military Leave, you will continue to be eligible for coverage under the Health Plans for up to 24 months of your leave, or until the day after the date you fail to apply for or return to work on a timely basis after your military leave, whichever is earlier.

Employees on Unpaid FMLA Leave or Unpaid Personal Leave
Generally, if you are on an approved unpaid FMLA or personal leave of absence, you will continue to be eligible for coverage under the Health Plans for the duration of your leave.

Employees on an unpaid leave of absence are responsible for paying the employee contribution amount for those benefits that require an employee contribution. You have two choices for paying any contributions due for the period of your unpaid leave of absence, which will be described in greater detail in the letter you receive setting forth the terms of your leave:

- Pre-Pay Contributions. You can make a lump-sum contribution due for the period of your leave (but not for any period beyond the end of the calendar year in which your leave begins) on a pre-tax basis (if appropriate) from the last paycheck before your leave begins. If your leave extends beyond the period for which you have prepaid your contribution amount, you may pay any additional required contributions under the Pay-As-You-Go method described below.
- Pay-As-You-Go Contributions. You can make monthly contributions during your leave on an after-tax basis. If you choose to make monthly contributions, you'll need to send your checks directly to the Benefits Department, on or before the first day of each pay period in which the contributions would have been deducted from your paycheck if you were actively employed. You must pay any delinquent contributions within 30 days of the date the payment is due; if any contribution amount remains unpaid after this 30-day period, your coverage will terminate.

Special Note for Unpaid Faculty Research Leave
If you are on an unpaid Faculty Research Leave, details related to your benefits eligibility will be included in the letter you receive explaining the terms of your leave of absence.

If You Die During Employment

If you die during your employment, your spouse and dependents will be eligible for COBRA coverage for 36 months. See ***Continuing Your Coverage after You Leave DePaul***.

If you die during your employment and would have otherwise been eligible to retire and to enroll in the Over-65 Retiree Plan, then your surviving spouse (or your surviving Unrelated SDA) and dependent child(ren) under the age of 26 (including children of your Unrelated SDA) will be eligible to enroll in the Retiree options. See ***When You Retire***.

If You Leave DePaul

If your employment with DePaul ends, your health coverage will end at the end of the month following your termination date. Refer to ***Continuing Your Coverage after You Leave DePaul*** for more information about your continuation options.

If you leave DePaul and are rehired within 31 days from the date on which your employment terminated, and you were previously enrolled in the Health Plans, you will be re-enrolled in the benefit options in which you were enrolled on your termination date. You will need to re-enroll on-line through myHr, but you cannot change your coverage choices unless a change would otherwise be permitted under the ***Changing Your Coverage*** section. Your coverage will be effective as of the first of the month following your date of rehire (unless re-employment is effective the first day of the month, in which case benefits are effective on the same day as your rehire date).

If you are rehired more than 31 days after your termination date or are rehired in a later calendar year, you will be given the opportunity to make new benefit elections with respect to your Health Plans coverage.

If You Transfer Employee Classifications

If you transfer from an employee classification that is eligible to participate in the Health Plans to an employee classification that is not eligible to participate in the Health Plans, you will remain eligible to participate in the Health Plans for the remainder of the plan year.

If you transfer from a full-time employee classification to a part-time employee classification, you will remain eligible to participate in the Health Plans for the remainder of the plan year; however, you will be eligible to elect coverage only under the Health Plans options offered to part-time employees.

If you transfer from a full-time employee classification to a student employee classification, you will remain eligible to participate in the Health Plans for the remainder of the plan year; however, you will be eligible to elect coverage only in the BlueEdge CDHP option under the Medical Plan.

For any employee who transfers to a different employee classification, benefits eligibility for the subsequent plan year will be determined in accordance with the eligibility rules described in the ***Who Is Eligible?*** section of the SPD.

When You Retire

When you retire, if you are not yet age 65, you and your eligible dependents may remain eligible to participate in the PPO option and the HMO Illinois option, if you meet the requirements described in the ***Eligibility Rules for Retirees*** section of this SPD.

If you retire when you are age 65 or older, you may be eligible to enroll in the Over-65 Retiree Plan. You also may be able to continue coverage for your eligible dependents under the PPO option and the HMO Illinois option, provided that your dependents are currently enrolled in the Health Plans at the time of your retirement. You can find out more about Retiree coverage by referring to the SPD for the Over-65 Retiree Plan.

WHEN COVERAGE ENDS

If you are covered under the Health Plans as an employee, your Health Plans coverage will end on the last day of the month in which any of the following occur:

- your employment with DePaul terminates for any reason;
- you exhaust short-term disability benefits while on a disability leave of absence (unless you subsequently receive long-term disability benefits and are eligible for coverage under the Medical

Plan as described in ***Employees on Disability Leave***), or you cease to qualify for short-term disability benefits but do not return to work;
- you are on an unpaid faculty research leave, the terms of which do not permit you to continue benefits; or
- you are on a military leave that extends beyond 24 months; or
- you lose eligibility for benefits under the Health Plans.

In addition, your Health Plans coverage will end on the date on which any of the following occur:

- you die;
- the Health Plans are terminated; or
- you stop making the contributions needed to pay for your coverage.

Generally, your dependent's coverage will end on the earliest of the following:

- the date your coverage ends (except in the event of your death, in which case your dependent's coverage will end on the last day of the month in which your death occurs unless he or she elects COBRA or is eligible to elect Medical coverage under a Retiree option as described in ***When You Retire***);
- in the case of your spouse or SDA, on the date he or she no longer qualifies as an eligible dependent;
- in the case of a dependent child, including your SDA's child, the last day of the month in which he or she no longer qualifies as an eligible dependent; or
- in the case of your SDA's child, on the day the SDA is no longer eligible for coverage.

You may be able to continue coverage at your own expense if coverage for you or your dependent ends. Similarly, your dependents may be able to continue their coverage should they lose eligibility. Refer to ***Continuing Your Coverage After You Leave DePaul***, or contact the Benefits Department to find out whether or not you can continue coverage.

If you change status without actually terminating employment (for example, you take a leave of absence), you should contact the Benefits Department for specific information regarding the effect on your coverage.

If you are covered under the Medical Plan as a pre-65 retiree, see the section ***Eligibility Rules for Retirees*** for details on when your and your dependents' coverage ends.

Rescission of Coverage

Your Medical Plan coverage may be cancelled or discontinued retroactively only if: (1) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required contributions for coverage, or (2) the cancellation or discontinuance of coverage is not considered to be a prohibited rescission under the Patient Protection and Affordable Care Act and applicable guidance. Your Medical Plan coverage may be rescinded if you perform an act, practice or omission that constitutes fraud in an enrollment form or in a claim for benefits, or if you make an intentional misrepresentation of material fact to the Plan Administrator regarding any information material to your eligibility for benefits. The Plan Administrator will provide you with written notice at least 30 days in advance of the rescission of your coverage. Any rescission of coverage is treated as a denial of benefits for purposes of the Medical Plan claims procedures. A retroactive termination due to your non-payment of contributions is not considered a rescission.

CONTINUING YOUR COVERAGE AFTER YOU LEAVE DEPAUL

COBRA

If you, your spouse and/or your dependent children (including a child of your SDA) lose coverage under the Health Plans as a result of a "qualifying event" as described in the following chart, you, your spouse and/or your dependent children may be eligible to continue benefits coverage at your expense for a limited period of time, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986

("COBRA"). In accordance with the rules described below, you will be provided with information and an opportunity to continue coverage under each individual plan (i.e., Medical Plan, Dental Plan and Vision Plan) in which you are enrolled at the time you experience a qualifying event. You may choose to continue coverage under some, all, or none of the benefit options in which you are enrolled at the time the qualifying event occurs.

COBRA rights do not extend to SDAs; however, DePaul offers certain continuation of coverage options for SDAs. See ***Continuation of SDA Coverage***.

Coverage Options other than COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you, your spouse and/or your dependent children through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

COBRA Qualifying Events and Duration of COBRA

The events and the maximum period for which you may continue coverage under COBRA include:

Qualifying Event	Who May Continue Coverage	Maximum Period of Coverage
Termination of employment (unless for gross misconduct) or reduction in hours	Employee, spouse, dependent child	18 months
Divorce	Former spouse, dependent child	36 months
Death of employee	Surviving spouse, dependent child	36 months
Dependent child loses eligibility	Dependent child	36 months

Notice Requirement and Electing Continuation Coverage

If the qualifying event is divorce, or your dependent child ceasing to be eligible for coverage, you or your dependents must inform the Benefits Department within 60 days of the last day of the month in which your divorce occurs to request notice of your COBRA continuation rights. You may provide notice orally, electronically or in writing. If you do not give notice within the required time period, you may not elect continuation coverage. If you provide timely notice of divorce or your dependent child ceasing to be eligible for coverage, the COBRA administrator will notify each qualified beneficiary of his or her right to continue coverage and provide the qualified beneficiary with the necessary information to complete an election. In all other cases, the COBRA administrator will notify you automatically of your right to continue coverage and provide you with the necessary information to complete an election.

You and your covered dependents will have 60 days from the later of the date coverage is lost, or the date the notice of the right to continuation coverage is received, to elect continuation coverage. If the election is not completed within the 60-day period, you will not have continuation coverage and will have no further rights to elect such coverage.

Coverage During the Election Period

As of the date coverage is terminated, you and your covered dependents will not have any coverage until you elect continuation coverage and pay the required premiums. This means no claims will be paid during the election period. In order to receive uninterrupted coverage, you should elect continuation coverage and make the required premium payments as soon as possible after receiving your notice of continuation coverage. See ***Cost of COBRA Continuation Coverage***.

If a completed election form is received and all required premiums are paid in a timely fashion, coverage becomes retroactive to the date coverage was terminated.

Second Qualifying Events

The maximum period for which you may elect continuation coverage is shown in the chart above. In some cases, however, you and/or your dependent may elect a longer period of coverage, based on the occurrence of a second qualifying event during the initial period of coverage. For example, if your dependent child has coverage because your employment terminates, and during the first 18 months of coverage ceases to be eligible because he or she is no longer a full-time student, then he or she may be eligible for an additional 18 months of coverage, for a total of 36 months of continuation coverage. To receive this additional continuation coverage, you or your dependents must notify the Benefits Department of the second qualifying event within 60 days of the event. Other events that may permit an extension of coverage are described in the next few paragraphs.

Medicare

If you become entitled to Medicare and later lose coverage under the plan due to your termination of employment or reduction in hours of employment, your covered dependents will be entitled to continuation coverage until the later of the date which is 36 months from the date you became entitled to Medicare or 18 months from the date of your termination of employment or reduction in hours of employment.

Disability Extension

If you or any of your covered dependents are found to be disabled for purposes of Social Security at the time of, or within 60 days of, your termination of employment/reduction in hours of employment, then you and your covered dependents are eligible to elect an additional 11 months of continuation coverage.

To purchase the additional 11 months of continuation coverage, you or your covered dependents must contact the COBRA administrator within 60 days of the date the determination of disability was made by the Social Security Administration and within the first 18 months of continuation coverage and provide proof of the Social Security Administration's determination of disability. If the Social Security Administration determines that the disabled member is no longer disabled, you or your covered dependents must contact the COBRA administrator within 30 days of the date of the determination. Continuation coverage will stop on the first day of the month that is at least 30 days after the member is determined not to be disabled.

Cost of COBRA Continuation Coverage

Your or your dependent's cost for continuation coverage is 102% of the full cost under the plan for providing coverage to a similarly situated active employee. If you or your dependent is entitled to elect the additional 11 months of continuation coverage in the case of disability, the premium for the additional 11-month period will increase to 150% of the full cost of providing coverage to a similarly situated active employee if the disabled member elects the extension. (If the disabled member does not elect the extension but other family members do, the applicable premium will remain at the 102% rate.) Your first payment is due 45 days after your election and must cover the period of time back to the first day of your COBRA continuation coverage. Subsequent payments are due once a month. Payment coupons will be sent to you after you elect continuation coverage. If the COBRA Administrator does not receive your monthly contribution within 30 days of the due date, continuation coverage will be canceled as of the last day of the month in which you paid a contribution.

If you qualify for coverage continuation under COBRA, you and your dependents may elect to continue the coverage you had at the time your regular coverage ends. However, at the time of your initial enrollment in COBRA continuation coverage, you may not add a dependent who was not covered previously, nor may you change your coverage election under the Medical Plan. However, you can choose not to cover a dependent who was covered previously. To drop a dependent, you must properly complete and submit the election notice to the claims administrator within 60 days of the event that made you eligible for COBRA coverage. Following your initial enrollment in COBRA continuation coverage, you may add dependents or change your coverage elections under the Medical Plan during the next open enrollment period, or if you experience a qualified change event.

A child who is born to you or placed for adoption with you during the COBRA continuation period also has the right to elect COBRA continuation coverage.

Termination Before the End of Maximum Coverage Period

Normally, your continuation coverage may be continued for the maximum period stated in the chart at the beginning of this section, as long as you or your covered dependents make timely payment of premiums. In some cases, however, continuation coverage may end before the maximum coverage period ends. Continuation coverage will terminate immediately if:

- DePaul no longer provides group health coverage to any of its employees,
- You or your covered dependents fail to pay the premium for the continuation coverage elected within 30 days of the first day of the month,
- After continuation coverage is elected, you or your covered dependents become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation that affects coverage of a covered individual's pre-existing condition, or
- After continuation coverage is elected, you or your covered dependents become eligible for Medicare.

In addition, the 11-month extension of continuation coverage due to disability will terminate as of the first day of the month beginning 30 days after the Social Security Administration determines that the covered dependent whose disability permitted the extension is no longer disabled. You must notify the Benefits Department within 30 days of such a determination.

COBRA benefits will be paid to the person who elected to continue coverage under COBRA or to the provider of services, if benefits are assigned.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you are on a qualified military leave that lasts longer than 31 days, USERRA allows you to continue coverage under rules similar to those for COBRA coverage. You may continue coverage for 24 months or the period of duty, whichever is less (this period also counts toward COBRA coverage). You pay the full cost of coverage for you and your dependents, plus a 2% administration fee (102% of the premium). Contact the Plan Administrator for more details. Continuation coverage under USERRA will run simultaneously with your COBRA period.

Continuation of SDA Coverage

COBRA provides for continuation of group health coverage for employees, their spouses and their eligible dependent children in certain situations. Although SDAs are not considered eligible dependents for purposes of COBRA, DePaul offers you the option to continue Medical Plan, Dental Plan and/or Vision Plan coverage for your SDA who is enrolled in the Health Plans under certain circumstances. This option is called "Continuation of Coverage."

An employee whose SDA loses coverage under any of the circumstances summarized in the chart below may elect Continuation of Coverage for the SDA in conjunction with the employee electing COBRA for his or her own coverage. The employee must pay the full cost of the SDA's coverage, plus the 2% administrative fee.

Qualifying Event	Maximum Continuation Period for a Second Domiciled Adult
The employee loses coverage because of reduced work hours or takes unpaid leave other than FMLA Leave	18 months
The employee's employment terminates for any reason other than gross misconduct	18 months

Note that if the employee is disabled (as defined by the Social Security Act) at the time of the qualifying event, or at any time during the first 60 days of continuation coverage, the maximum continuation period may be extended to 29 months from the date of the qualifying event. See ***Disability Extension*** above for details.

With respect to the qualifying events described above, only the employee may elect Continuation of Coverage for an SDA.

Continuation of Coverage Following Death of an Employee

In addition to the qualifying events described above, an SDA may elect Continuation of Coverage if he or she loses coverage due to the covered employee's death. The maximum continuation period for Continuation of Coverage elected following the death of an employee is 36 months.

Continuation of Coverage is not available to an SDA if loss of coverage is due to one of the following events:

- The SDA relationship ends;
- The SDA's eligibility ends for any reason; or
- The employee enrolls in Medicare.

Continuation of coverage for an SDA may end earlier than described above, upon any of the following:

- The employee (or SDA as applicable) fails to pay the required premium;
- The employee's own COBRA coverage terminates (except with respect to Continuation of Coverage following an employee's death); or
- The employee (or SDA as applicable) notifies DePaul that he or she wishes to discontinue the SDA's coverage.

Note About Continuation Coverage for HMO Illinois and Vision Plan

If you participate in the HMO Illinois option and/or the Vision Plan, then you and your dependents may have special Illinois continuing coverage rights. These rights may include the option to convert your group health insurance coverage to a similar health insurance coverage arrangement offered through Blue Cross and Blue Shield of Illinois ("BCBS"). For more information about Illinois continuation coverage rights, including conversion rights, you should refer to your HMO Illinois Insurance Certificate (or call BCBS at 800-458-6024) or contact Vision Service Plan's customer service department at 800-877-7195.

MEDICAL PLAN DETAILS

Medical Plan Options

The DePaul University Medical Plan (the "Medical Plan") offers you a number of options from which to choose, all of which are administered by Blue Cross Blue Shield:

- **Consumer Driven Health Plan** – Refer to the ***BlueEdge CDHP*** section.
- **Preferred Provider Organization (PPO)** – Refer to the ***Blue Cross Blue Shield PPO*** section.
- **Health Maintenance Organization (HMO)** – Refer to the ***HMO Illinois*** section.

You pay for your coverage under the Medical Plan with payroll deductions. If you would like more information about how coverage rates are calculated and how payments are deducted, refer to the ***Plan Funding and Paying for Your Health Coverage*** section.

Covered Health Services

Health services described in this section are covered when such services are:

- considered **"Covered Health Services"** (refer to the ***Medical Plan Definitions*** section);
- provided by or under the direction of your primary physician or other appropriate provider as specifically described;
- determined to be **"Medically Necessary"** (refer to the ***Medical Plan Definitions*** section); and
- not excluded as described in the ***General Exclusions*** section.

Covered health services are subject to co-payments and/or co-insurance as described in the ***Schedule of Benefits*** sections. In addition, the payment level for covered health services under the BlueEdge CDHP option and the PPO option is based on the **"Eligible Charge"** and may be different when you use an in-network provider than when you use an out-of-network provider. Refer to the ***BlueEdge CDHP*** and ***Blue Cross Blue Shield PPO*** sections, as well as the ***Medical Plan Definitions*** section, for more details about the Eligible Charge.

Only health care services that are described in this ***Covered Health Services*** section are covered under the Medical Plan. The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, sickness or mental illness does not mean that the procedure or treatment is covered under the Medical Plan.

For any services or procedure not specifically addressed in this SPD, the Health Plans will follow Blue Cross Blue Shield's standard procedure or limitation. For additional information, or for a list of services that are covered under the Medical Plan, you should call Blue Cross Blue Shield directly at 800-458-6024, or you may access information online by signing in as a member at www.bcbsil.com and selecting "View Medical Coverage."

Covered Providers

Refer to the definition of **"Provider"** in the ***Medical Plan Definitions*** section. To determine if a particular provider "type" or provider "class" is covered, you should contact BCBS directly at 800-458-6024, or visit the BCBS website at www.bcbsil.com and sign in as a member to view information about your medical coverage.

Access to Medical Plan Information Online

You can find more details about the Medical Plan options and your benefits online at www.bcbsil.com. The first time you access the BCBS website, you will need to create a member login ID in order to obtain information about your benefits. To create a member login ID, select "I'm a Member," then select "Need a User Name? Register Now." From there, follow the instructions to create your member login ID.

Coverage Comparisons of Medical Plan Program Options

The following tables summarize and compare the general features of each of the program options available under the Medical Plan.

IN-NETWORK: General Coverage Comparison for All Medical Plan Program Options[1]

	BlueEdge CDHP	BCBS PPO	HMO Illinois
Employer HSA Contribution	Full-Time Employees: $500 single; $1,000 > single Part-Time Employees: $250 single; $500 > single	n/a	n/a
Annual Deductible	$2,000 single; $4,000 family	$500 single; $1,000 family	n/a
Annual Out-of-Pocket Maximum	$3,000 single; $6,000 family	$2,500 single; $5,000 family	$2,000 single; $4,000 family (includes medical - $1,500/$3,000 and Rx - $500/$1,000)
PCP Required	No	No	Yes
Office Visit	80%	100% after $30 co-pay for primary care 100% after $50 co-pay for specialist and therapy services	100% after $30 co-pay for primary care 100% after $50 co-pay for specialist and therapy services
In-patient Hospital Services	80%	80%	100% after $250 hospitalization co-pay
Preventive Care Services[3]	100%[2]	100%[2]	100%
Rx – Retail[4] (generally, up to a 34-day supply)	Generic: 80% minimum co-insurance* = $10 per prescription maximum co-insurance = $100 per prescription Formulary: 70% minimum co-insurance* = $10 per prescription maximum co-insurance = $125 per prescription Non-Formulary: 65% minimum co-insurance* = $10 per prescription maximum co-insurance = $150 per prescription	Generic: 80%[2] minimum co-insurance* = $10 per prescription maximum co-insurance = $100 per prescription Formulary: 70%[2] minimum co-insurance* = $10 per prescription maximum co-insurance = $125 per prescription Non-Formulary: 65%[2] minimum co-insurance* = $10 per prescription maximum co-insurance = $150 per prescription	Generic: 80% minimum co-insurance* = $10 per prescription maximum co-insurance = $100 per prescription Formulary: 70% minimum co-insurance* = $10 per prescription maximum co-insurance = $125 per prescription Non-Formulary: 65% minimum co-insurance* = $10 per prescription maximum co-insurance = $150 per prescription
Rx – Mail Order[4] (up to a 90-day supply)	Your co-pay: Generic: $25 Formulary: $60 Non-Formulary: $100	Your co-pay[2]: Generic: $25 Formulary: $60 Non-Formulary: $100	Your co-pay: Generic: $25 Formulary: $60 Non-Formulary: $100
Emergency Room	80%	80%	100% after your $75 co-pay (waived if admitted)
Mental Health / Substance Abuse	Paid the same as any other condition	Paid the same as any other condition	Paid the same as any other condition

*If the cost of the prescription is less than the minimum, the participant will pay only the cost of the prescription.

OUT-OF-NETWORK: General Coverage Comparison for All Medical Plan Program Options[1]

	BlueEdge CDHP	BCBS PPO	HMO Illinois
Employer HSA Contribution	Full-Time Employees: $500 single; $1,000 > single Part-Time Employees: $250 single; $500 > single	n/a	n/a
Annual Deductible	$4,000 single; $8,000 family	$1,000 single; $2,000 family	n/a
Annual Out-of-Pocket Maximum	$6,000 single; $12,000 family	$5,000 single; $10,000 family	n/a

PCP Required	No	No	n/a
Office Visit	60%	60%	Not Covered
In-patient Hospital Services	60%	60%	Not Covered
Preventive Care Services	60%	60%	Not Covered
Rx – Retail[4] (up to a 34-day supply)	Generic: 80% minimum co-insurance* = $10 per prescription maximum co-insurance = $100 per prescription Formulary: 70% minimum co-insurance* = $10 per prescription maximum co-insurance = $125 per prescription Non-Formulary: 65% minimum co-insurance* = $10 per prescription maximum co-insurance = $150 per prescription	Generic: 80%[2] minimum co-insurance* = $10 per prescription maximum co-insurance = $100 per prescription Formulary: 70%[2] minimum co-insurance* = $10 per prescription maximum co-insurance = $125 per prescription Non-Formulary: 65%[2] minimum co-insurance*= $10 per prescription maximum co-insurance = $150 per prescription	Not Covered
Rx – Mail Order (up to a 90-day supply)	Not Covered	Not Covered	Not Covered
Emergency Room	80%	80%	100% after your $75 co-pay (waived if admitted)
Mental Health / Substance Abuse Treatment	Paid the same as any other condition	Paid the same as any other condition	Not Covered

*If the cost of the prescription is less than the minimum, the participant will pay only the cost of the prescription.

Footnotes

1. Unless otherwise noted, all services are subject to annual deductibles.
2. Not subject to annual deductible.
3. Follow-up doctor visits and tests performed as a result of a potential health problem discovered during preventive care screenings are covered as normal medical expenses rather than as preventive care. For example, a colonoscopy performed as a result of a potential problem discovered during a routine physical would not be covered as a preventive care benefit; rather, it would be covered as a normal medical procedure.
4. Under the prescription drug program, the member pays the applicable coinsurance and/or co-pay plus the difference between the cost of the brand and generic drug if the brand drug is selected. If physician indicates dispense as written, member does not pay the difference in cost.

BlueEdge CDHP

The **BlueEdge CDHP** is in a class of medical benefit plans collectively known as **Consumer Driven Health Plans**. In general, the class includes any type of employer-sponsored health benefits plan or initiative that seeks to give employees greater responsibility for choosing their own health care and provides incentives for employees to seek high quality and cost-effective care.

The Blue Edge CDHP is a self-insured option, which means claims are paid from the contributions Medical Plan participants make and from the general assets of DePaul. The BlueEdge CDHP combines a high deductible health plan with a health savings account ("HSA"). Blue Cross Blue Shield of Illinois is responsible for providing the provider network and administering the BlueEdge CDHP option.

Limits on the annual deductibles, out-of-pocket maximums, and maximum annual contributions are set by the IRS. The IRS also requires that participants using an HSA can be covered only by a qualifying high deductible health plan. Therefore the *only* Medical Plan option available to DePaul HSA participants is the BlueEdge CDHP.

Eligibility Requirements

You are not eligible to enroll in the BlueEdge CDHP if you are:

- covered by another health plan (including a general purpose health flexible spending account), unless it is a qualified high deductible health plan;

- claimed as a dependent on another person's tax return; or
- enrolled in Medicare.

Your spouse is not eligible to enroll in the BlueEdge CDHP if he or she is:

- covered by another health plan, unless it is a qualified high deductible health plan;
- claimed as a dependent on another person's tax return; or
- enrolled in Medicare.

Your SDA and/or dependent child is eligible to enroll in the BlueEdge CDHP only if he or she meets the eligibility requirements described above in ***Eligibility Rules for Your Spouse or Your Second Domiciled Adult*** or ***Eligibility Rules for Your Child or Your SDA's Child***, as applicable.

BlueEdge CDHP – Schedule of Benefits*

HSA – ANNUAL AMOUNT FUNDED BY DEPAUL: This amount can be used to pay for eligible health expenses.	**Full-Time Employees: $500 Single; $1,000 > Single** **Part-Time Employees: $250 Single; $500 > Single**	
LIFETIME COMPREHENSIVE MAJOR MEDICAL COVERAGE: Total lifetime maximum.	**Unlimited**	
	In-Network	**Out-of-Network**
DEDUCTIBLE: Per calendar year. Family deductible must be met before any family member receives benefits under the Health Plans. In-Network and Out-of-Network deductibles cross feed each other (*i.e.,* in-network charges apply to the out-of-network deductible and vice versa).	$2,000 single $4,000 family	$4,000 single $8,000 family
OUT-OF-POCKET EXPENSE LIMITATION: The amount of money an individual pays toward covered medical expenses during any one calendar year. In-Network and Out-of-Network charges cross feed each other. Charges exceeding the Schedule of Maximum Allowances (SMA) do not apply to any out-of-pocket limit. Out-of-Network payments are based on SMA. Members can be balance billed.	$3,000 single $6,000 family	$6,000 single $12,000 family
PREVENTIVE CARE: The BlueEdge CDHP option covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/preventive-care-benefits/	100%, deductible does not apply	60%
INPATIENT SERVICES • **HOSPITAL:** Room allowance based on hospital's semi-private room rate. Includes pre-admission testing, home care, hospice, skilled nursing (limited to 100 days). • **INPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY:** Paid the same as any other inpatient admission.	80%	60%
OUTPATIENT SERVICES • **HOSPITAL:** Including radiation, chemotherapy, nuclear scans (MRI, CAT, PET). • **OUTPATIENT SURGERY & DIAGNOSTIC TESTS:** Hospital & Physician. • **OUTPATIENT REHABILITATION:** Includes Cardiac/Pulmonary (limit of 36 visits), physical therapy, occupational therapy, speech therapy, and chiropractic services (chiropractic limited to 20 sessions). Limit of 60 sessions combined for physical, occupational, speech and chiropractic therapies). • **OUTPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY:** Paid the same as other outpatient conditions.	80%	60%
PHYSICIAN MEDICAL/SURGICAL CARE: Payments are based on the Eligible Charge. *Includes medical and surgical care, anesthetics, durable medical equipment, etc.*	80%	60%
DOCTOR'S OFFICE VISITS: Includes specialist visits, medical services provided in a doctor's or specialist's office.	80%	60%
INFERTILITY: No lifetime maximum on or after January 1, 2011.	80%	60%
EMERGENCY: (Hospital) Emergency Medical and Emergency Accident - Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions following the standard emergency criteria. If an inpatient admission occurs thereafter, the MSA must be contacted within two business days.	80%	80%
OTHER COVERED SERVICES: Blood and blood components; leg, arm, and neck braces; private duty nursing; Temporomandibular Joint Dysfunction (No LTM limit on or after January 1, 2011); ambulance services; surgical dressings, casts and splints; prosthetic devices. Some states do not solicit certain provider types, if no In-Network provider exists, claims will be payable at 90%.	80%	80%

PRESCRIPTION DRUGS: Benefits are available for drugs purchased from a participating pharmacy or professional provider (retail) or through the home delivery program. Benefits for retail drugs are provided for up to a maximum of a 34 consecutive day supply. Mail order provides up to a 90 day supply of maintenance drugs. The member pays the coinsurance plus the difference when a brand name drug is selected and a generic option is available. If physician indicates dispense as written, the member does not pay difference between brand and generic.	**Retail** Generic: You pay 20% after deductible ($10 min, $100 max) Formulary: You pay 30% after deductible ($10 min, $125 max) Non-Formulary: You pay 35% after deductible ($10 min, $150 max) **Mail Order** Co-pay after deductible: $25 generic $60 formulary $100 non-formulary	**Retail** Generic: You pay 20% after deductible ($10 min, $100 max) Formulary: You pay 30% after deductible ($10 min, $125 max) Non-Formulary: You pay 35% after deductible ($10 min, $150 max) **Mail Order**: N/A
TRANSPLANT COVERAGE: Heart, heart/lung, lung, pancreas, pancreas/kidney, liver transplants in approved facilities paid as any other condition with prior MSA approval.		
MEDICAL SERVICES ADVISORY (MSA): Notification required prior to all elective admissions. Emergency and obstetric admission notification required within two working days of admittance. Pre-certification is also required for Inpatient Admission, Skilled Nursing Facilities, Private Duty Nursing, and Home Health Care. **If employee elects not to notify MSA Advisor or follow advice given, hospital benefits will be reduced by $500. Benefits will then be paid as per this plan's provisions.**		
PRE-EXISTING CONDITIONS WAITING PERIOD: None		
DEPENDENT ELIGIBILITY: To age 26 (or to age 30 for dependents who are military veterans) subject to the eligibility conditions described in the ***Eligibility Rules for Your Spouse or Your SDA*** and ***Eligibility Rules for Your Child or Your SDA's Child*** sections of the SPD.		
COORDINATION OF BENEFITS: This program coordinates benefits with other group plans.		

*Unless otherwise noted, all services are subject to annual deductibles.

BlueEdge HSA

If you participate in the BlueEdge CDHP, you have the option to make pre-tax contributions to an interest bearing HSA to cover medical, dental, and vision expenses as well as future health care premiums such as for COBRA and retiree medical premiums. Note, however, that student employees who participate in the BlueEdge CDHP are not eligible to contribute to an HSA.

If you enroll in the BlueEdge HSA as an active employee, DePaul will make an annual contribution to your HSA as soon as administratively feasible following the later of (1) the date on which you elect to participate in the BlueEdge CDHP option under the Health Plans; or (2) the date on which you establish an HSA through ACS/Mellon Bank. For full-time employees, the amount of DePaul's contribution will be $500 if you are enrolled in single coverage, and $1,000 if you are enrolled in employee + spouse, employee + child, or family coverage. For part-time employees, the amount of DePaul's contribution will be $250 if you are enrolled in single coverage, and $500 if you are enrolled in employee + spouse, employee + child, or family coverage. If you enroll in the BlueEdge CDHP mid-year, the contribution will be pro-rated to reflect the date of your enrollment. DePaul will not make contributions on behalf of an employee who is a COBRA participant or on behalf of a student employee.

This section provides general information about using an HSA to reimburse eligible medical expenses. For more details, visit https://hr.depaul.edu/Benefits/Health_Welfare/Consumer/index.html.

Some of the advantages of using an HSA include:

- tax-free contributions and reimbursements for eligible expenses;
- freedom to use any provider or hospital;
- unused funds carry over from year to year;
- interest earned on HSA funds;
- portability of funds if you change jobs or retire;

- use of funds to pay medical expenses while not employed including at retirement; and
- available information and support to make better health care decisions.

Who Is Eligible to Contribute to an HSA
You are eligible to contribute to an HSA if you meet the following criteria:

- You are enrolled in a high deductible health plan such as the BlueEdge CDHP. (To qualify as a high deductible health plan in 2018, a plan must have an annual deductible of at least $1,350 for individual coverage or at least $2,700 for family coverage.)
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return.
- You are not covered by another health plan that is not a high deductible health plan and that provides benefits already covered under the BlueEdge CDHP. This includes coverage received through your spouse's medical plan, or participation in a Health Care FSA (including if your spouse participates in a standard Health Care Flexible Spending Account).

You can, however, still contribute to an HSA if you have additional insurance that provides benefits only for the following items:

- liabilities incurred under workers' compensation laws, tort liabilities or liabilities related to ownership or use of property;
- a specific disease or illness; or
- a fixed amount per day (or other period) of hospitalization.

You can also contribute to an HSA even though you have insurance coverage for accidents, disability, dental care, vision care, or long-term care.

Annual Limit on HSA Contributions
The law limits the total amount (employer + employee contributions) that may be contributed to an HSA each year. In 2018, the maximum HSA contribution amounts are $3,450 for individual coverage and $6,900 for family coverage. These limits are periodically adjusted to reflect the current legal limit on HSA contributions for a given year. Note that, if you are married and your spouse also has an HSA (either in connection with DePaul coverage, or in connection with another employer's medical plan), the amount you are permitted to contribute to your HSA for the year may be lower than the amount indicated above. If you think this may affect your HSA contributions, you should contact ACS/Mellon for more details.

Who Is Eligible to Use the Money in an HSA
The IRC requires that you use the funds in your HSA only for eligible expenses incurred by you or your "qualifying dependents." For purposes of HSA reimbursement, a "qualifying dependent" includes your spouse, your qualifying child and your qualifying relative, defined as follows:

A **qualifying child** for HSA purposes must be your child (generally your biological child, adopted child, stepchild or eligible foster child, although other relations may qualify), and the child must:

- as of the last day of the year, be under age 19, under age 24 if a full-time student, or any age if permanently and totally disabled;
- provide 50% or less of his or her own support for the year; and
- reside at your principal place of residence for more than six months of the year (excluding temporary absences, such as for school).

If a child does not meet the criteria to be your qualifying child, he or she may instead be your **qualifying relative** for HSA purposes if he or she:

- is either your child (generally your biological child, adopted child, stepchild or eligible foster child, although other relations may qualify), or a child who has the same principal residence as you for the entire year and is a member of your household;
- receives more than 50% of his or her support from you; and
- is not your or anyone else's qualifying child dependent.

Your SDA may be your **qualifying relative** for HSA purposes if he or she:

- is a member of your household who lives with you for the full tax year;
- receives more than 50% of his or her support from you; and
- is not your or anyone else's "qualifying child" dependent.

Special Rule for Child of Parents Who Are Divorced or Separated

A special exception applies in the case of a child of parents who are divorced or legally separated, or who live apart at all times during the last six months of the calendar year. Such a child may be your "qualifying dependent" for HSA purposes, even if the child is not your qualifying child or qualifying relative, if the child:

- receives over 50% of his or her support during the year from his or her parents,
- is in the custody of one or both parents for more than 50% of the year, and
- qualifies as a tax dependent of one of his or her parents under IRC Section 152(c) or 152(d).

How the BlueEdge CDHP Option Works

If you have medical expenses, the BlueEdge CDHP option may cover all or part of the expenses based on the provisions in this section and this SPD.

Special Note on Electing a Health Care Flexible Spending Account

If you elect the BlueEdge CDHP option and elect to contribute to a health care flexible spending account (FSA), you may not receive reimbursement from the FSA for medical expenses. However, you can use the FSA funds to be reimbursed for dental and vision care expenses. Refer to the separate summary plan description for the DePaul University Flexible Spending Account Program for more information.

In-Network and Out-Of-Network Coverage

The BlueEdge CDHP uses a network of hospitals and physicians that have agreed to accept a scheduled, discounted rate for their services. Both you and DePaul benefit from these discounted rates. For example, if you obtain health care services from a network doctor, the Medical Plan will pay 80% and you will pay 20% of a discounted charge after you satisfy the deductible.

You may choose to visit any health care provider included in the network without a referral, and eligible expenses will be paid at 80% after satisfying the deductible. When you visit providers who are not in the network, charges are paid at 60% after satisfying a larger deductible. Also, when visiting an out-of-network provider or facility, you should expect to pay 100% of the cost at the time of service and then submit a claim for reimbursement directly to BCBS. See ***Receiving Your Benefits – Claims Procedures***.

Eligible Charge

The payment level for medical services is based on the Eligible Charge (as generally defined below) and may vary if you use an in-network provider or an out-of-network provider. The "Eligible Charge" for medical services obtained from an in-network provider is the amount that the provider has agreed with BCBS to accept as payment in full for a particular medical service. The "Eligible Charge" for medical services obtained from an out-of-network provider is the lesser of (1) the provider's billed charges, or (2) the amount that BCBS determines to be the Eligible Charge for a particular medical service, developed from the base Medicare reimbursement rate and representing approximately 100% of the base Medicare reimbursement rate for the medical service (excluding any Medicare adjustments made based on information specific to your claim). Therefore, the Eligible Charge will be different in most cases (and in many cases, less) when you use an out-of-network provider than when you use an in-network provider. In addition, if you use an out-of-network provider, you may be billed for the balance remaining after the provider is reimbursed by BCBS. For the full definition of "Eligible Charge," please refer to the ***Medical Plan Definitions*** section.

Your Deductibles

Note that except for in-network preventive health services, all benefits provided under the BlueEdge CDHP (including prescription drug benefits) are subject to the annual deductible, which means that before the Medical Plan begins to pay any benefit, the applicable annual deductible must first be met. This is a

requirement of the IRS, that must be followed in order to make the BlueEdge CDHP a qualified high deductible plan which can be used with an HSA.

The amount of your deductible depends on whether you use an in-network provider or an out-of-network provider. However, any out-of pocket expenses that are applied towards the in-network deductible are also applied towards the out-of-network deductible and vice versa. Once you have met your individual deductible or any combination of family members have met the family deductible, the Medical Plan pays benefits for your covered expenses. Note: If you have family coverage, no separate individual deductible applies. One covered member or combination of members must reach the indicated family deductible in order for the deductible to be satisfied.

Your Co-Insurance and Out-of-Pocket Maximum

The BlueEdge CDHP option pays a percentage of most eligible in-network and out-of-network expenses after the annual deductible has been satisfied. The percentage you are required to pay towards covered health services is called your "co-insurance." Refer to the ***Schedule of Benefits*** in this section for the specific co-insurance and deductible levels.

The out-of-pocket maximum is the most you will pay towards the charges for covered expenses each calendar year, including your deductible, co-insurance and co-payments. Once you reach this maximum, the Medical Plan pays 100% of the charges for covered services for the remainder of the calendar year.

Your out-of-pocket maximums are different for in-network and out-of-network services; however, all of your covered expenses will apply to both your in-network and out-of-network limits, unless otherwise noted in this SPD. Refer to the ***Schedule of Benefits*** in this section for out-of-pocket maximums.

Maximum Lifetime Benefit

There is no overall lifetime benefit maximum under the BlueEdge CDHP option.

Special Benefit Maximums

Certain specific benefits may be subject to special benefit maximums that limit either the amount of money the Medical Plan will pay for treatment, or the number of treatments/visits to a treatment facility that the Medical Plan will cover.

The following medical care is subject to special benefit maximums:

- Skilled nursing facility/inpatient rehabilitation facility services;
- Outpatient rehabilitation services;
- Cardiac rehabilitation services; and
- Chiropractic health services.

Expenses for services that exceed the special benefit maximum are not covered under the BlueEdge CDHP. To learn more about the specific benefit maximums that apply to these services, you can refer to the ***Schedule of Benefits*** in this section, sign in as a member at www.bcbsil.com and select "View Medical Coverage," or call BCBS directly at 800-458-6024.

Health Care Services Related to Organ or Tissue Transplants

Special rules and requirements apply to health services that you receive related to organ or tissue transplants. For specific information about these rules and requirements, contact BCBS at 800-458-6024 or sign in as a member at www.bcbsil.com and select "View Medical Coverage."

Prior Authorization

Some health services require prior authorization, which is the approval a participating provider must receive from BCBS prior to rendering services, in order for certain services and benefits to be covered under the BlueEdge CDHP. Failure to obtain prior authorization for the services below will result in your benefits being reduced by $500. The $500 will not be applied toward your out-of-pocket maximum.

Services that require prior authorization include, but are not limited to:

- in-patient hospital services;

- skilled nursing facility services;
- home health care;
- private duty nursing services; and
- partial hospitalization programs.

The ultimate decisions about medical care must be made by you and your physician. BCBS determines only whether the listed service or supply is a covered health service according to the Medical Plan benefits and provisions.

Procedures for Obtaining Health Services

All coverage is subject to the provisions of this section and other limitations and exclusions of the Health Plans.

Health Services Rendered by Network Providers

You are eligible for coverage for health services described in the ***Covered Health Services*** section if such health services are provided by or under the direction of your eligible physician. All coverage is subject to the terms, conditions, exclusions and limitations of the Health Plans.

Enrolling for coverage under the BlueEdge CDHP does not guarantee health services from a particular network provider on the list of providers. This list of network providers is subject to change. When a provider on the list is no longer a network provider, you must choose among remaining network providers or pay the out-of-network benefit rate.

Coverage for health services is subject to payment of the required contributions for coverage under the BlueEdge CDHP and payment of the co-insurance specified for any service.

Selection of a Primary Physician

The BlueEdge CDHP option gives members the freedom to visit a specialist without a referral from a primary care physician ("PCP"). Since having a PCP can provide a very valuable relationship, members are encouraged to choose a PCP to coordinate their care and treatment, although members are not required to do so. You have the right to designate any PCP who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. For more information on how to select a PCP, contact BCBS at 800-458-6024, or visit www.bcbsil.com and sign in as a member to view information about your medical coverage.

Verification of Participation Status

You are responsible for verifying the participation status of the physician, hospital, or other provider prior to receiving health services. You are also responsible for verifying that you are enrolled in the BlueEdge CDHP, and you must show your ID card every time you request health services, including every time you obtain a prescription drug product from a participating pharmacy. If you fail to verify participation status or to show your ID card, and that failure results in noncompliance with required Medical Plan procedures, coverage of network benefits may be denied.

Emergency Health Services

The BlueEdge CDHP provides coverage of eligible expenses for "Emergency Health Services" (as defined in the ***Medical Plan Definitions*** section), subject to the terms, conditions, exclusions, and limitations of the Health Plans. You should contact your primary physician whenever possible prior to seeking Emergency Health Services, and you should seek care from the provider he or she designates.

Emergency Health Services by Non-Network Providers

If you obtain emergency health services from a non-network provider, you must notify BCBS within 48 hours after the emergency health services are initially provided, or as soon as reasonably possible if you are confined due to the emergency medical condition. At the request of BCBS, you must make available full details of the emergency health services you received, in order for such health services to be covered as network benefits.

Coverage for continuation of care after the condition no longer is an emergency medical condition requires coordination by your primary physician and the prior authorization of BCBS. If you are hospitalized, you may be required under the terms of the BlueEdge CDHP to transfer to a network hospital as soon as it is medically appropriate to do so to continue to receive network benefits. Services rendered by non-network providers are not covered as network benefits if you choose to remain in a non-network facility after you have been notified of BCBS' intent to transfer you to a network facility.

Special Note Regarding Prescription Drug Coverage

Certain prescription drugs require your prescribing physician to obtain prior authorization from BCBS or its designee for such prescription drugs to be covered under the Plan and/or require you to obtain certain prescription drugs through a specific mail order pharmacy for such prescription drugs to be covered under the Plan. There are three prescription drug programs, described below, which include additional requirements:

- **Prior Authorization Program** – Under this program, prior authorization is required to receive coverage for certain high-cost medications that have the potential for misuse.
  - General Program Rules
    - If your provider prescribes a medication that requires prior authorization, your provider must submit a prior authorization request to BCBS before the medication will be covered under the BlueEdge CDHP option.
    - If the prior authorization request is approved, you will pay the appropriate amount based on your prescription drug coverage.
    - If the prior authorization request is not approved, you will be responsible for paying the full cost of the medication, if you choose to fill your prescription.
  - Examples of Medication Categories Included in the Prior Authorization Program
    - androgens/anabolic steroids
    - antibiotics (e.g., doxycycline/minocycline)
    - antifungal agents
    - erectile dysfunction
    - fentanyl (oral/nasal)
    - narcolepsy
    - opioid dependence
    - specialty medications
    - hyperpolarization-activated cyclic nucleotide-gated (HCN) channel blockers
    - opioid induced constipation medications
    - neprilysin inhibitors
  - For more information about the prescription drugs included in the Prior Authorization Program, visit bcbsil.com/member/rx_drug_choices.html, select your applicable plan coverage, and scroll down to the Prior Authorization/Step Therapy Program section

- **Step Therapy Program** – Under this program, a "step" approach is required to receive coverage for certain high-cost medications.
  - General Program Rules
    - Medications are considered either "first-line" or "second-line" medications.
    - As a general rule, your provider is required to first prescribe a "first-line" medication to treat you (this "first-line" step is a covered benefit under the BlueEdge CDHP option).
    - If your provider then determines that a "second-line" medication is necessary, the "second-line" step will be a covered benefit under the BlueEdge CDHP option.
  - If Your Provider Determines that a "First-Line" Medication Is Not Appropriate for You
    - If your provider determines that a "first-line" medication is not appropriate for you or is not effective in treating your condition, the BlueEdge CDHP option will cover a "second-line" medication when certain conditions are satisfied. For more information, you should call the Pharmacy Program number located on the back of your ID card, or visit www.bcbsil.com, sign in as a member, and select "View Medical Coverage."
  - Examples of Medication Categories Included in the Step Therapy Program
    - antidepressants
    - diabetes
    - lipid management

- biological immunomodulators
- iron chelators
- multiple sclerosis
- atopic dermatitis
- fibrate
- ophthalmic prostaglandins/glaucoma
- atypical antipsychotics
- topical NSAIDS

- **Prime Specialty Pharmacy Program** – Under this program, you are required to obtain certain specialty medications through Prime Specialty Pharmacy, which will coordinate filling your prescription and ship your medication overnight.
  - General Program Rules
    - For certain specialty medications, you will need to contact Prime Specialty Pharmacy to set up your prescription and delivery.
    - Prime Specialty Pharmacy will coordinate setting up the prescription, shipping your medication overnight, and consulting with the prescribing physician as needed.
  - Examples of Medication Categories Included in the Prime Specialty Pharmacy Program
    - Crohns disease
    - hemophilia
    - hepatitis C
    - psoriasis
    - rheumatoid arthritis
    - multiple sclerosis
    - oral oncology

The lists of prescription drugs included in the Prior Authorization Program, the Step Therapy Program and the Prime Specialty Pharmacy Program are subject to periodic review and modification by BCBS. In addition, certain prescription drugs are excluded from coverage under the BlueEdge CDHP option. For the most current information about prescription drug coverage under the BlueEdge CDHP option, call the Pharmacy Program at the phone number located on the back of your ID card, or go online at www.bcbsil.com and sign in as a member to view information about your coverage.

Coverage While Traveling

BCBS offers the BlueCard program to make it easier for you to obtain quality health care treatment when traveling. With the BlueCard program, you can receive treatment at participating hospitals and receive the same benefits you would receive if treated in the Chicago area. Rather than having to pay the full bill when you receive treatment and then waiting for reimbursement, you pay only for non-covered services, your deductible, and coinsurance. For BlueCard in the US, regular in-network and out-of-network benefits apply. Contact BCBS regarding participating hospitals in the United States.

For international travel, benefits are available through the BlueCard Worldwide program and are coordinated through the Blue Cross Blue Shield Association. Members can access the Blue Cross Blue Shield Association's providers by signing in to the BCBS website at www.bcbsil.com. For members traveling outside the US, benefits will be paid at the in-network level, regardless of the provider's participation in the network; however, it may be necessary for the member to pay up-front at the time of service and then submit for reimbursement from BCBS afterward.

Blue Cross Blue Shield PPO

The PPO option is a self-insured medical program, which means claims are paid from the contributions Medical Plan participants make and from the general assets of DePaul. Blue Cross Blue Shield of Illinois is responsible for providing the PPO network and administering the PPO option.

Blue Cross Blue Shield PPO – Schedule of Benefits*

LIFETIME COMPREHENSIVE MAJOR MEDICAL COVERAGE: Total lifetime maximum for all benefits received through the Blue Cross Blue Shield PPO option	**Unlimited**	
	In-Network	**Out-of-Network**
DEDUCTIBLE: Per individual, per calendar year. In-Network and Out-of-Network deductibles cross feed each other. (*i.e.,* in-network charges apply to the out-of-network deductible and vice versa).	$500	$1,000
FAMILY DEDUCTIBLE: (Aggregate)	$1,000	$2,000
OUT-OF-POCKET EXPENSE LIMITATION: The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. In-Network and Out-of-Network charges cross feed each other. Charges exceeding the Schedule of Maximum Allowances (SMA) do not apply to any out-of-pocket limit. Out-of-Network payments are based on SMA, members can be balance billed.	$2,500 single $5,000 family (aggregate)	$5,000 single $10,000 family (aggregate)
PREVENTIVE CARE: The PPO option covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/preventive-care-benefits/	100%, deductible does not apply	60%
INPATIENT SERVICES • **HOSPITAL:** Room allowance based on hospital's semi-private room rate. Includes pre-admission testing, home care, hospice, skilled nursing (limited to 100 days). • **INPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY:** Paid the same as any other inpatient service.	80%	60%
OUTPATIENT SERVICES • **HOSPITAL:** Including radiation and chemotherapy, nuclear scans (MRI, CAT, PET). • **OUTPATIENT SURGERY & DIAGNOSTIC TESTS:** Hospital & Physician. • **OUTPATIENT REHABILITATION:** Includes Cardiac/Pulmonary (limit of 36 visits), physical therapy, occupational therapy, speech therapy, and chiropractic services (chiropractic limited to 20 sessions). • **OUTPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY:** Paid the same as any other outpatient service.	80%	60%
PROFESSIONAL OFFICE VISITS: Includes primary care, specialist care and mental health and chemical dependency therapy visits.	100%, after: $30 co-pay for primary care $50 co-pay for specialist & therapy	60%
PHYSICIAN MEDICAL/SURGICAL CARE: Payments are based on the Eligible Charge. *Includes medical and surgical care, anesthetics, durable medical equipment, etc.*	80%	60%
INFERTILITY: No lifetime maximum on or after January 1, 2011.	80%	60%
EMERGENCY: (Hospital) Emergency Medical and Emergency Accident - Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions following the standard emergency criteria (the most liberal definition). If an inpatient admission occurs thereafter, the MSA must be contacted within two business days.	80%	80%
OTHER COVERED SERVICES: Blood and blood components; leg, arm, and neck braces; private duty nursing; Temporomandibular Joint Dysfunction (No LTM limit on or after January 1, 2011); ambulance services; surgical dressings, casts and splints; prosthetic devices. Some states do not solicit certain provider types, if no PPO network exists claims will be payable at 90%.	80%	80%
PRESCRIPTION DRUGS: Not subject to deductible. Benefits are available for drugs purchased from a participating pharmacy or professional provider (retail) or through the home delivery program (deductible does not apply). Benefits for retail drugs are provided for up to a maximum of a 34 consecutive day supply. Mail order provides up to a 90 day supply of maintenance drugs. The member pays the coinsurance or co-pay plus the difference when a brand name drug is selected and a generic option is available. If physician indicates dispense as written, the member does not pay difference between brand and generic.	**Retail** Generic: You pay 20% ($10 min, $100 max) Formulary: You pay 30% ($10 min, $125 max)	**Retail** Generic: You pay 20% ($10 min, $100 max) Formulary: You pay 30% after deductible ($10 min, $125 max)

	Non-Formulary: You pay 35% ($10 min, $150 max) **Mail Order** Co-pay: $25 generic $60 formulary $100 non-formulary	Non-Formulary: You pay 35% ($10 min, $150 max) **Mail Order**: N/A
TRANSPLANT COVERAGE: Heart, heart/lung, lung, pancreas, pancreas/kidney, liver transplants in approved facilities paid as any other condition with prior MSA approval.		
MEDICAL SERVICES ADVISORY (MSA): Notification required prior to all elective admissions. Emergency and obstetric admission notification required within two working days of admittance. Pre-certification is required for Inpatient Admission, Skilled Nursing Facilities, Private Duty Nursing, and Home Health Care. **If employee elects not to notify MSA Advisor or follow advice given, hospital benefits reduced by $500. Benefits will then be paid per plan provisions.**		
PRE-EXISTING CONDITIONS WAITING PERIOD: None		
DEPENDENT ELIGIBILITY: To age 26 (or to age 30 for dependents who are military veterans) subject to the eligibility conditions described in the ***Eligibility Rules for Your Spouse or Your SDA*** and ***Eligibility Rules for Your Child or Your SDA's Child*** sections of the SPD.		
COORDINATION OF BENEFITS: This program coordinates benefits with other group plans.		

*Unless otherwise noted, all services are subject to annual deductibles.

How the Blue Cross Blue Shield PPO Option Works

If you have medical expenses, the PPO option may cover all or part of the expenses based on the provisions in this section and this SPD.

In-Network and Out-of-Network Coverage

The PPO option has a network of hospitals and physicians that have agreed to accept a scheduled, discounted rate for their services. Both you and DePaul benefit from these discounted rates. For example, if you obtain health care services from a network doctor, the Medical Plan will pay 80% and you will pay 20% of a discounted charge after you satisfy the deductible.

You may choose to visit any health care provider included in the PPO network without a referral, and charges will be paid at 80% of the scheduled amount after you satisfy your annual deductible. When you visit providers who are not in the network, charges are paid at 60% after you satisfy a larger deductible. Also, when visiting an out-of-network provider or facility, you should expect to pay 100% of the cost at the time of service and then submit a claim for reimbursement directly to BCBS. See ***Receiving Your Benefits – Claims Procedures***.

Eligible Charge

The payment level for medical services is based on the Eligible Charge (as generally defined below) and may vary if you use an in-network provider or an out-of-network provider. The "Eligible Charge" for medical services obtained from an in-network provider is the amount that the provider has agreed with BCBS to accept as payment in full for a particular medical service. The "Eligible Charge" for medical services obtained from an out-of-network provider is the lesser of (1) the provider's billed charges, or (2) the amount that BCBS determines to be the Eligible Charge for a particular medical service, developed from the base Medicare reimbursement rate and representing approximately 100% of the base Medicare reimbursement rate for the medical service (excluding any Medicare adjustments made based on information specific to your claim). Therefore, the Eligible Charge will be different in most cases (and in many cases, less) when you use an out-of-network provider than when you use an in-network provider. In addition, if you use an out-of-network provider, you may be billed for the balance remaining after the provider is reimbursed by BCBS. For the full definition of "Eligible Charge," please refer to the ***Medical Plan Definitions*** section.

Your Deductibles

Note that except for in-network preventive health services, in-network professional office visits that are subject to a co-payment, and prescription drug benefits, all benefits provided under the PPO option are subject to the annual deductible, which means that before the Medical Plan begins to pay any benefit, the applicable annual deductible must first be met.

The amount of your deductible depends on whether you use an in-network provider or an out-of-network provider. However, any out-of pocket expenses that are applied towards the in-network deductible are also applied towards the out-of-network deductible and vice versa. Once you have met your individual deductible or any combination of family members have met the family deductible, the Medical Plan pays benefits for your covered expenses. Note: If you have family coverage, no separate individual deductible applies. One covered member or combination of members must reach the indicated family deductible in order for the deductible to be satisfied.

Your Co-Payments

A co-payment is the charge that you are required to pay for certain health services provided under the PPO option. A co-payment is generally a defined flat-dollar amount. You are responsible for the payment of any co-payment for network benefits directly to the provider of the health service at the time of service, or when billed by the provider. None of your co-payments apply to the annual deductible.

Your Co-Insurance and Out-of-Pocket Maximum

The PPO option pays a percentage of most eligible in-network and out-of-network expenses after the annual deductible has been satisfied. The percentage you are required to pay towards covered health services is your "co-insurance." Refer to the ***Schedule of Benefits*** in this section for the specific co-insurance and deductible levels.

The out-of-pocket maximum is the most you will pay towards the charges for covered expenses each calendar year, including your deductible, co-insurance, and co-payments. Once you reach this maximum, the Medical Plan pays 100% of the charges for most covered services for the remainder of the calendar year.

Your out-of-pocket maximums are different for in-network and out-of-network services; however, all of your covered expenses will apply to both your in-network and out-of-network maximums unless otherwise noted in this SPD. Refer to the ***Schedule of Benefits*** in this section for out-of-pocket maximums.

Special Fourth Quarter Carryover Provision

If you incur eligible expenses during the last three months of a calendar year that are or could be applied to that year's deductible, those expenses will also count toward satisfying the deductible for the following calendar year.

Maximum Lifetime Benefit

There is no overall lifetime benefit maximum under the PPO option.

Special Benefit Maximums

Certain specific benefits may be subject to special benefit maximums that limit either the amount of money the Medical Plan will pay for treatment, or the number of treatments/visits to a treatment facility that the Medical Plan will cover.

The following medical care is subject to special benefit maximums:

- Skilled nursing facility/inpatient rehabilitation facility services;
- Cardiac rehabilitation services; and
- Chiropractic health services.

Expenses for services that exceed the special benefit maximum are not covered under the PPO option. To learn more about the specific benefit maximums that apply to these services, you can refer to the ***Schedule of Benefits*** in this section, sign in as a member at www.bcbsil.com and select "View Medical Coverage," or call BCBS directly at 800-458-6024.

Health Care Services Related to Organ or Tissue Transplants

Special rules and requirements apply to health services that you receive related to organ or tissue transplants. For specific information about these rules and requirements, contact Blue Cross Blue Shield at 800-458-6024, or visit www.bcbsil.com, sign in as a member and select "View Medical Coverage."

Prior Authorization
Some health services require pre-certification, which is the approval a member must receive from BCBS prior to services being rendered, in order for such services and benefits to be covered under the PPO option. Failure to obtain prior authorization for the services below will result in your benefits being reduced by $500. The $500 will not be applied toward your out-of-pocket maximum.

Services that require prior authorization include, but are not limited to:

- in-patient hospital services;
- skilled nursing facility services;
- home health care;
- private duty nursing services; and
- partial hospitalization programs.

Members are required to contact Blue Cross Blue Shield one business day prior to an in-patient admission, skilled nursing facility, private duty nursing, or coordinated home care, or two business days after a maternity admission or an admission for an emergency medical condition. Pre-certifying your services does not guarantee benefits.

The ultimate decisions about medical care must be made by you and your physician. BCBS determines only whether the listed service or supply is a covered health service according to the Medical Plan benefits and provisions.

Procedures for Obtaining Health Services

All coverage is subject to the provisions of this section and other limitations and exclusions of the Health Plans.

Health Services Rendered by In-Network Providers
You are eligible for coverage for health services described in the ***Covered Health Services*** section if such health services are considered to be covered health services and are provided by or under the direction of your eligible physician. All coverage is subject to the terms, conditions, exclusions and limitations of the Health Plans.

Enrolling for coverage under the PPO option does not guarantee health services from a particular network provider on the list of providers. This list of network providers is subject to change. When a provider on the list is no longer a network provider, you must choose among remaining network providers or pay the out-of-network benefit rate.

Coverage for health services is subject to payment of the required contributions for coverage under the PPO option and payment of the co-payment or co-insurance specified for any service.

Selection of a Primary Physician
The PPO option gives members the freedom to visit a specialist without a referral from a primary care physician ("PCP"). Since having a PCP can provide a very valuable relationship, members are encouraged to choose a PCP to coordinate their care and treatment, although members are not required to do so. You have the right to designate any PCP who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. For more information on how to select a PCP and to find current, specific provider information, contact BCBS at 800-458-6024, or visit www.bcbsil.com and sign in as a member to view information about your medical coverage.

Verification of Participation Status
You are responsible for verifying the participation status of the physician, hospital, or other provider prior to receiving health services. You are also responsible for verifying that you are enrolled in the PPO option, and you must show your ID card every time you request health services, including every time you obtain a prescription drug product from a participating pharmacy. If you fail to verify participation status or

to show your ID card, and that failure results in noncompliance with required Medical Plan procedures, coverage of network benefits may be denied.

Referral Health Services
It is not necessary for you to select a PCP in the PPO option, and you may seek treatment from a specialist at any time, without a referral.

In the event that specific health services cannot be provided by or through a network provider, you may be eligible for network benefits when covered health services are obtained through non-network providers. In this event, BCBS must be notified and must authorize network benefits for non-network health services in advance.

Emergency Health Services
The PPO option provides coverage of eligible expenses for "Emergency Health Services" (as defined in the ***Medical Plan Definitions*** section), subject to the terms, conditions, exclusions, and limitations of the Health Plans. You should contact your primary physician whenever possible prior to seeking emergency health services, and you should seek care from the provider he or she designates.

Emergency Health Services by Non-Network Providers
If you obtain emergency health services from a non-network provider, you must notify BCBS within 48 hours after the emergency health services are initially provided, or as soon as reasonably possible if you are confined due to the emergency medical condition. At the request of BCBS, you must make available full details of the emergency health services you received, in order for such health services to be covered as network benefits.

Coverage for continuation of care after the condition no longer is an emergency medical condition requires coordination by your primary physician and the prior authorization of BCBS. If you are hospitalized, you may be required under the terms of the PPO option to transfer to a network hospital as soon as it is medically appropriate to do so to continue to receive network benefits. Services rendered by non-network providers are not covered as network benefits if you choose to remain in a non-network facility after you have been notified of BCBS' intent to transfer you to a network facility.

Special Note Regarding Prescription Drug Coverage
Certain prescription drugs require your prescribing physician to obtain prior authorization from BCBS or its designee for such prescription drugs to be covered under the Plan and/or require you to obtain certain prescription drugs through a specific mail order pharmacy for such prescription drugs to be covered under the Plan. There are three prescription drug programs, described below, which include additional requirements:

- **Prior Authorization Program** – Under this program, prior authorization is required to receive coverage for certain high-cost medications that have the potential for misuse.
  - General Program Rules
    - If your provider prescribes a medication that requires prior authorization, your provider must submit a prior authorization request to BCBS before the medication will be covered under the PPO option.
    - If the prior authorization request is approved, you will pay the appropriate amount based on your prescription drug coverage.
    - If the prior authorization request is not approved, you will be responsible for paying the full cost of the medication, if you choose to fill your prescription.
  - Examples of medication categories Included in the Prior Authorization Program
    - androgens/anabolic steroids
    - antibiotics (e.g., doxycycline/minocycline)
    - antifungal agents
    - erectile dysfunction
    - fentanyl (oral/nasal)
    - narcolepsy
    - opioid dependence
    - specialty medications

        - hyperpolarization-activated cyclic nucleotide-gated (HCN) channel blockers
        - opioid induced constipation medications
        - neprilysin inhibitors
    - For more information about the prescription drugs included in the Prior Authorization Program, visit bcbsil.com/member/rx_drug_choices.html, select your applicable plan coverage, and scroll down to the Prior Authorization/Step Therapy Program section

- **Step Therapy Program** – Under this program, a "step" approach is required to receive coverage for certain high-cost medications.
    - General Program Rules
        - Medications are considered either "first-line" or "second-line" medications.
        - As a general rule, your provider is required to first prescribe a "first-line" medication to treat you (this "first-line" step is a covered benefit under the PPO option).
        - If your provider then determines that a "second-line" medication is necessary, the "second-line" step will be a covered benefit under the PPO option.
    - If Your Provider Determines that a "First-Line" Medication Is Not Appropriate for You
        - If your provider determines that a "first-line" medication is not appropriate for you or is not effective in treating your condition, the PPO option will cover a "second-line" medication when certain conditions are satisfied. For more information, you should call the Pharmacy Program number located on the back of your ID card, or visit www.bcbsil.com, sign in as a member, and select "View Medical Coverage."
    - Examples of Medication Categories Included in the Step Therapy Program
        - antidepressants
        - diabetes
        - lipid management
        - biological immunomodulators
        - iron chelators
        - multiple sclerosis
        - atopic dermatitis
        - fibrate
        - ophthalmic prostaglandins/glaucoma
        - atypical antipsychotics
        - topical NSAIDS

- **Prime Specialty Pharmacy Program** – Under this program, you are required to obtain certain specialty medications through Prime Specialty Pharmacy, which will coordinate filling your prescription and ship your medication overnight.
    - General Program Rules
        - For certain specialty medications, you will need to contact Prime Specialty Pharmacy to set up your prescription and delivery.
        - Prime Specialty Pharmacy will coordinate setting up the prescription, shipping your medication overnight, and consulting with the prescribing physician as needed.
    - Examples of Medication Categories Included in the Prime Specialty Pharmacy Program
        - Crohns disease
        - hemophilia
        - hepatitis C
        - psoriasis
        - rheumatoid arthritis
        - multiple sclerosis
        - oral oncology

The lists of prescription drugs included in the Prior Authorization Program, the Step Therapy Program and the Prime Specialty Pharmacy Program are subject to periodic review and modification by BCBS. In addition, certain prescription drugs are excluded from coverage under the PPO option. For the most current information about prescription drug coverage under the PPO option, call the Pharmacy Program at the phone number located on the back of your ID card, or go online at www.bcbsil.com and sign in as a member to view information about your coverage.

Coverage While Traveling

BCBS offers the BlueCard program to make it easier for you to obtain quality health care treatment when traveling. With the BlueCard program, you can receive treatment at participating hospitals and receive the same benefits you would receive if treated in the Chicago area. Rather than having to pay the full bill when you receive treatment and then waiting for reimbursement, you pay only for non-covered services, your deductible, and coinsurance. For BlueCard in the US, regular in-network and out-of-network benefits apply. Contact BCBS regarding participating hospitals in the United States.

For international travel, benefits are available through the BlueCard Worldwide program and are coordinated through the Blue Cross Blue Shield Association. Members can access the Blue Cross Blue Shield Association's providers by signing in to the BCBS website at www.bcbsil.com. For members traveling outside the US, benefits will be paid at the in-network level, regardless of the provider's participation in the network; however, it may be necessary for the member to pay up-front at the time of service and then submit for reimbursement from BCBS afterward.

HMO Illinois

HMO Illinois is a fully insured product, which means that HMO Illinois insures and funds all benefits under this option. HMO Illinois also provides the HMO network and administers the HMO Illinois option.

HMO Illinois – Schedule of Benefits

LIFETIME COMPREHENSIVE MAJOR MEDICAL COVERAGE: Total lifetime maximum.	**Unlimited**	
	In-Network	**Out-of-Network**
DEDUCTIBLE: Per calendar year.	N/A	N/A
OUT-OF-POCKET EXPENSE LIMITATION: The amount of money an individual pays toward covered medical expenses during any one calendar year. Excludes Vision co-pays.	$2,000 / Individual $4,000 / Family Note: Out-of-pocket expense limitation includes both medical and Rx. Medical = $1,500 Individual / $3,000 Family Rx = $500 Individual / $1,000 Family	N/A
PRIMARY CARE PHYSICIAN (PCP) REQUIRED: PCP must coordinate or approve care.	Yes	N/A
PREVENTIVE CARE: The HMO Illinois option covers "preventive health services," as that term is defined by the Patient Protection and Affordable Care Act of 2010, as amended, and implementing regulations thereunder. For more information about the specific preventive health services that are covered, visit https://www.healthcare.gov/preventive-care-benefits/	100%	Not covered
HOSPITAL SERVICES: Including Inpatient services, home care, skilled nursing facility, hospice care, and Outpatient surgery (hospital and physician charges).	100% after $250 Hospitalization Co-pay	Not covered
INPATIENT SERVICES • **INPATIENT MENTAL HEALTH AND CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:** Paid the same as any other inpatient admission.	100%	Not covered
OUTPATIENT SERVICES • **OUTPATIENT MENTAL HEALTH AND CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:** Paid the same as any other outpatient condition.	100% after $30 Co-pay	Not covered
• **OUTPATIENT REHABILITATION SERVICES:** Includes physical, occupational, or speech therapy. Limit of 60 visits combined per calendar year. • **OUTPATIENT SPEECH THERAPY** • **OUTPATIENT SURGICAL SERVICES**	100% after $50 Co-pay	Not covered
PHYSICIAN MEDICAL/SURGICAL CARE: Includes medical and surgical care, anesthetics, etc.	100% after $50 Co-pay	Not covered
DOCTOR'S OFFICE VISITS: Includes specialist visits and medical services provided in a doctor's or specialist's office. No co-pay applies if no physician charge assessed. For maternity services, the $30 co-pay only applies to the first visit.	$30 Co-pay for primary care $50 Co-pay for specialist	Not Covered
INFERTILITY: Some services may be subject to coverage restrictions.	100% after $50 Co-pay	Not covered
EMERGENCY: (Hospital) Emergency Medical and Emergency Accident - Initial treatment in hospital of accidental injuries or sudden and unexpected medical conditions following the standard emergency criteria.	100% after $75 Co-pay (waived if admitted)	100% after $75 Co-pay (waived if admitted)
OTHER COVERED SERVICES: Ambulance services; surgical dressings, casts and splints; durable medical equipment; prosthetic devices; hospice.	100%	Not covered
PRESCRIPTION DRUGS: Benefits are available for drugs purchased from a participating pharmacy or professional provider (retail) or through the home delivery program. Benefits for retail drugs are provided for up to a maximum of a 34 consecutive day supply. Mail order provides up to a 90 day supply of maintenance drugs. 90 day supply also	**Retail** Generic: You pay 20%	Not covered

available at select Retail Stores.	($10 min, $100 max) Formulary: You pay 30% ($10 min, $125 max) Non-Formulary: You pay 35% ($10 min, $150 max) **Mail Order** Co-pay: $25 generic $60 formulary $100 non-formulary	
VISION CARE: Exams covered once every 12 months. Eyewear allowance of $75 every 24 months, plus discounts. Member pays the remainder of eyewear cost after the discount.	100% for eye exam, $75 allowance for glasses/contacts	Not covered
PRE-EXISTING CONDITIONS WAITING PERIOD: None		
DEPENDENT ELIGIBILITY: To age 26 (or to age 30 for dependents who are military veterans) subject to the eligibility conditions described in the ***Eligibility Rules for Your Spouse or Your SDA*** and ***Eligibility Rules for Your Child or Your SDA's Child*** sections of the SPD.		
COORDINATION OF BENEFITS: This program coordinates benefits with other group plans.		

How the HMO Illinois Option Works

If you have medical expenses, the HMO Illinois option may cover all or part of the expenses based on the provisions in this section of this SPD.

The HMO Illinois option requires the selection of a primary care physician ("PCP"). Your PCP will be responsible for providing your medical services and coordinating your care for specialist services. You must obtain a referral from your PCP for specialist services, with the exception of OB/GYN services. All services must be performed by or require referral from your Primary Care Physician or Woman's Principal Health Care Provider except for emergency health services, substance abuse services, or annual eye exams.

In order for health services to be covered, you must receive care from providers in the network. So that you will not be required to pay bills for non-covered services, you should always verify the participation status of a physician, hospital or other provider, prior to receiving services. From time to time, the participation status of a provider may change. You can verify the participation status by calling HMO Illinois, and, if necessary, HMO Illinois can provide assistance in referring you to network providers.

The ultimate decisions about medical care must be made by you and your physician. HMO Illinois determines only whether the listed service or supply is a covered health service according to the Medical Plan benefits and provisions.

Your Co-Payments

A co-payment is the charge that you are required to pay for certain health services provided under the HMO Illinois option. A co-payment is generally a defined flat-dollar amount. You are responsible for the payment of any co-payment for network benefits directly to the provider of the health service at the time of service or when billed by the provider.

Your Co-Insurance and Out-of-Pocket Maximum

The HMO Illinois option pays 100% of most eligible medical expenses. However, certain services may require a co-payment or other out-of-pocket expense. The out-of-pocket maximum is the most you will pay towards the charges for covered expenses each plan year. Once you reach this maximum, the Medical Plan pays 100% of most eligible medical expenses including the co-payment. Refer to the ***Schedule of Benefits*** in this section for the specific co-payment amounts and out-of-pocket maximums, including the separate out-of-pocket maximum amounts that apply to medical expenses and prescription drug benefits.

Maximum Lifetime Benefit
There is no overall lifetime benefit maximum under the HMO Illinois option.

Special Benefit Maximums
Certain specific benefits may be subject to special benefit maximums that limit either the amount of money the Medical Plan will pay for treatment, or the number of treatments/visits to a treatment facility that the Medical Plan will cover.

The following medical care is subject to special benefit maximums:

- Outpatient rehabilitative therapy;
- Outpatient speech therapy; and
- Vision care benefits (provided under HMO Illinois, not the separate Vision Plan).

Expenses for services that exceed the special benefit maximum are not covered under the HMO Illinois option. To learn more about the specifid benefit maximums that apply to these services, you can refer to the ***Schedule of Benefits*** in this section, sign in as a member at www.bcbsil.com and select "View Medical Coverage," or call HMO Illinois at 800-892-2803.

Health Care Services Related to Organ or Tissue Transplants
Special rules and requirements apply to health services that you receive related to organ or tissue transplants. For specific information about these rules and requirements, contact HMO Illinois at 800-892-2803 or sign in as a member at www.bcbsil.com and select "View Medical Coverage."

Procedures for Obtaining Health Services

Health Services Rendered by Network Providers
You are eligible for coverage for health services described in ***Covered Health Services*** if such health services are considered to be covered health services and are provided by or under the direction of your primary care physician. All coverage is subject to this section and the terms, conditions, exclusions and limitations of the Health Plans.

Enrolling for coverage under the HMO Illinois option does not guarantee health services by a particular network provider on the list of providers. This list of network providers is subject to change. When a provider on the list is no longer a network provider, you must choose among remaining network providers.

Coverage for health services is subject to payment of the required contributions for coverage under the HMO Illinois option and payment of the co-payment specified for any service.

Special Note Regarding Prescription Drug Coverage
Certain prescription drugs require your prescribing physician to obtain prior authorization from HMO Illinois or its designee for such prescription drugs to be covered under the Plan. There are two HMO Illinois programs, described below, that require prior authorization:

- **Prior Authorization Program** – Under this program, prior authorization is required to receive coverage for certain high-cost medications that have the potential for misuse.
  - General Program Rules
    - If your provider prescribes a medication that requires prior authorization, your provider must submit a prior authorization request to HMO Illinois before the medication will be a covered benefit under the HMO Illinois option.
    - If the prior authorization request is approved, you will pay the appropriate amount based on your prescription drug coverage.
    - If the prior authorization request is not approved, you will be responsible for paying the full cost of the medication, if you choose to fill your prescription.
  - Examples of medication categories Included in the Prior Authorization Program
    - androgens/anabolic steroids
    - antibiotics (e.g., doxycycline/minocycline)
    - antifungal agents

- erectile dysfunction
- fentanyl (oral/nasal)
- narcolepsy
- opioid dependence
- specialty medications
- hyperpolarization-activated cyclic nucleotide-gated (HCN) channel blockers
- opioid induced constipation medications
- neprilysin inhibitors

- **Step Therapy Program** – Under this program, a "step" approach is required to receive coverage for certain high-cost medications.
  - General Program Rules
    - Medications are considered either "first-line" or "second-line" medications.
    - As a general rule, your provider is required to first prescribe a "first-line" medication to treat you (this "first-line" step is a covered benefit under the HMO Illinois option).
    - If your provider then determines that a "second-line" medication is necessary, the "second-line" step will be a covered benefit under the HMO Illinois option.
  - If Your Provider Determines that a "First-Line" Medication Is Not Appropriate for You
    - If your provider determines that a "first-line" medication is not appropriate for you or is not effective in treating your condition, HMO Illinois will cover a "second-line" medication when certain conditions are satisfied. For more information, you should call the Pharmacy Program number located on the back of your ID card, or visit www.bcbsil.com, sign in as a member, and select "View Medical Coverage."
  - Examples of Medication Categories Included in the Step Therapy Program
    - antidepressants
    - diabetes
    - lipid management
    - biological immunomodulators
    - iron chelators
    - multiple sclerosis
    - atopic dermatitis
    - fibrate
    - ophthalmic prostaglandins/glaucoma
    - atypical antipsychotics
    - topical NSAIDS

The lists of prescription drugs included in the Prior Authorization Program and the Step Therapy Program are subject to periodic review and modification by HMO Illinois. In addition, certain prescription drugs are excluded from coverage under the HMO Illinois option. For the most current information about prescription drug coverage under the HMO Illinois options, call the Pharmacy Program at the phone number located on the back of your ID card, or go online at www.bcbsil.com and sign in as a member to view information about your medical coverage.

In addition, you may choose to participate in the **Prime Specialty Pharmacy Program**, which allows you to obtain certain specialty medication through Prime Specialty Pharmacy, which will coordinate filling your prescription and ship your medication overnight.

- General Program Rules
  - For certain specialty medications, you may contact Prime Specialty Pharmacy to set up your prescription and delivery.
  - Prime Specialty Pharmacy will coordinate setting up the prescription, shipping your medication overnight, and consulting with the prescribing physician as needed.
- Examples of Medication Categories Included in the Prime Specialty Pharmacy Program
  - Crohns disease
  - hemophilia
  - hepatitis C
  - psoriasis
  - rheumatoid arthritis
  - multiple sclerosis

- oral oncology

The lists of prescription drugs included in the Prime Specialty Pharmacy Program are subject to periodic review and modification by BCBS. For the most current lists, call the Pharmacy Program at the phone number located on the back of your ID card, or go online at www.bcbsil.com and sign in as a member to view information about your medical coverage.

Selection of a Primary Physician

When you enroll in the HMO Illinois option, you select a participating Individual Practice Association (IPA) and a Primary Care Physician ("PCP") or a Participating Medical Group.

If you enroll in family coverage, members of your family may select a different participating IPA and PCP or Participating Medical Group. You must choose a PCP for each of your family members from the selected Participating IPA or Participating Medical Group.

You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. For more information on how to select a PCP, contact HMO Illinois at 800-892-2803 or visit Blue Access for Members at www.bcbsil.com.

You do not need prior authorization from HMO Illinois or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology; however, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact HMO Illinois at 800-892-2803 or visit Blue Access for Members at www.bcbsil.com.

If you are a female member, you may choose to designate a Woman's Principal Health Care Provider (who is affiliated with or employed by your Participating IPA or Participating Medical Group) in addition to your PCP. A Woman's Principal Health Care Provider may be seen for care without referrals from your PCP, but your PCP and your Woman's Principal Health Care Provider must have a referral arrangement with one another. Contact your Participating IPA or Participating Medical Group, your PCP or Woman's Principal Health Care Provider or HMO Illinois for a list of providers with whom your PCP and/or your Woman's Principal Health Care Provider has a referral arrangement.

Your PCP is responsible for coordinating all of your health care needs. In the case of female members, your health care needs may be coordinated by your PCP or your Woman's Principal Health Care Provider, if applicable.

To be eligible for benefits through HMO Illinois, the services you receive must be provided by or ordered by your PCP and/or your Woman's Principal Health Care Provider.

Verification of Participation Status

You are responsible for verifying the participation status of the physician, hospital, or other provider prior to receiving health services. You are also responsible for verifying that you are enrolled in the HMO Illinois option, and you must show your ID card every time you request health services, including every time you obtain a prescription drug product from a participating pharmacy. If you fail to verify participation status or to show your ID card, and that failure results in noncompliance with required Medical Plan procedures, coverage of network benefits may be denied.

Referral Health Services

To receive benefits for treatment from another physician or provider, you must be referred to that provider by your Primary Care Physician or Woman's Principal Health Care Provider. That referral must be in writing and must specifically state the services that are to be rendered. Benefits will be limited to those specifically stated services.

If you have an illness or injury that needs ongoing treatment from another physician or provider, you may apply for a standing referral to that physician or provider from your PCP or Woman's Principal Health Care Provider. Your PCP or Woman's Principal Health Care Provider may authorize the standing referral, which shall be effective for the period necessary to provide the referred services or for a period of up to one year.

The only time that you can receive benefits for services not ordered by your PCP or Woman's Principal Health Care Provider is when you are receiving emergency health services, treatment for chemical dependency, or routine vision examinations.

In the event that specific health services cannot be provided by or through a network provider, you may be eligible for network benefits when covered health services are obtained through non-network providers. In this event, your Participating IPA or Participating Medical Group must be notified and must authorize non-network health services in advance.

Changing Your Primary Care Physician or Woman's Principal Health Care Provider
You may change your choice of PCP or Woman's Principal Health Care Provider to one of the other physicians in your Participating IPA or Participating Medical Group by notifying your Participating IPA or Participating Medical Group of your desire to change. Contact your Participating IPA or Participating Medical Group, your PCP or Woman's Principal Health Care Provider, or HMO Illinois to obtain a list of providers with whom your PCP and/or Woman's Principal Health Care Provider have a referral arrangement.

Changing Your Participating IPA or Participating Medical Group
You may change from your Participating IPA or Participating Medical Group to another Participating IPA or Participating Medical Group by calling HMO Illinois at 800-892-2803. The change will be effective the first day of the month following your call. However, if you are an inpatient or in the third trimester of pregnancy at the time of your request, the change will not be effective until you are no longer an inpatient or until your pregnancy is completed.

When necessary, Participating IPAs or Participating Medical Groups have the right to request the removal of members from their enrollment. Their request cannot be based upon the type, amount or cost of services required by any member. If HMO Illinois determines that the Participating IPA or Participating Medical Group has sufficient cause and approves such a request, such members will be offered enrollment in another Participating IPA or Participating Medical Group. The change will be effective no later than the first day of the month following 45 days from the date the request is received.

Selecting a Different Participating IPA or Participating Medical Group for Your Newborn
You may select a Participating IPA or Participating Medical Group for your newborn child. Your newborn will remain with the mother's Participating IPA or Participating Medical Group or Woman's Principal Health Care Provider, if one has been selected, from the date of birth until he or she is discharged from the Hospital.

In-Area Treatment of an Emergency Medical Condition
You are considered to be in your Participating IPA's or Participating Medical Group's treatment area if you are within 30 miles of your Participating IPA or Participating Medical Group. Although you may go directly to the nearest hospital emergency room to obtain treatment for an emergency medical condition, you are recommended to contact your PCP or Woman's Principal Health Care Provider first if you are in your Participating IPA's or Participating Medical Group's treatment area. Benefits will be provided for the hospital and physician services that he or she authorizes.

If you obtain emergency health services in the hospital emergency room, your PCP or Woman's Principal Health Care Provider must be notified of your condition as soon as possible, and benefits will be limited to the emergency health services required for treatment of your emergency medical condition, unless further treatment is ordered by your PCP or Woman's Principal Health Care Provider. If in-patient Hospital care is required, it is especially important for you or your family to contact your PCP or Woman's Principal Health

Care Provider as soon as possible. All Participating IPAs or Participating Medical Groups have 24-hour phone service.

Payment for In-Area Emergency Health Services
Benefits for emergency health services received in your Participating IPA's or Participating Medical Group's treatment area will be paid at 100% of the provider's charge. However, each time you receive emergency health services in a hospital emergency room, you will be responsible for the emergency room co-payment. Refer to the ***Schedule of Benefits*** in this section. If you are admitted to the hospital as an in-patient immediately after you receive emergency health services, the emergency room co-payment will be waived.

Out-of-Area Treatment of an Emergency Medical Condition
If you are more than 30 miles away from your Participating IPA or Participating Medical Group and need to obtain treatment for an emergency medical condition, benefits will be provided for the hospital and physician services that you receive. Benefits are available for the emergency health services required for treatment of your emergency medical condition, and for related follow-up care, but only if it is not reasonable for you to obtain the follow-up care from your PCP or Woman's Principal Health Care Provider. If you are not sure whether or not you are in your Participating IPA's or Participating Medical Group's treatment area, call them and they will tell you.

Payment for Out-of-Area Treatment of an Emergency Medical Condition
Benefits for emergency health services received outside of your Participating IPA's or Participating Medical Group's treatment area will be paid at 100% of the provider's charge. However, each time you receive emergency health services in a hospital emergency room, you will be responsible for the emergency room co-payment. Refer to the ***Schedule of Benefits*** in this section. If you are admitted to the Hospital as an Inpatient immediately after you receive emergency health services, the emergency room co-payment will be waived.

Special Note on Changing Your Coverage
If you are covered under the HMO Illinois option and you move out of the HMO service area, you may elect coverage under any other available program option under the Medical Plan. You may also change your coverage category. You must contact the Benefits Department and complete a status change application within 31 days of the move.

Identification Cards for the Medical Plan Program Options

When you enroll in one of the Medical Plan options, you will receive an ID card identifying you as a participant in that particular option. You should carry your ID card with you and present it to your health care provider whenever you need medical services, including when you obtain a prescription drug product from a participating pharmacy.

If you do not show your ID card, the network providers have no way of knowing that you are covered under the Medical Plan, and you may receive a bill for health care services or the charge may not be accurately applied to your deductible. If you do not show your ID card at the time you obtain a prescription drug product from a participating pharmacy, you will be required to pay the full cost of the prescription drug product and seek reimbursement. In that case, your reimbursement will be calculated at the predominant contract reimbursement rate for the specific drug (which is a rate that is determined in the contract between BCBS and the pharmacy), including any sales tax, less the applicable co-insurance.

You may contact BCBS by calling the phone number listed on your ID card, and BCBS may contact you by phone to assist you and your physician with access to health care services.

Relationship Between the Parties

The relationships between BCBS, HMO Illinois and network providers; and relationships between BCBS, HMO Illinois and DePaul, are solely contractual relationships between independent contractors. Network

providers and DePaul are not agents or employees of BCBS or HMO Illinois, nor is BCBS or HMO Illinois (or any employee of BCBS or HMO Illinois) an agent or employee of network providers or of DePaul.

The relationship between a network provider and any covered person is that of provider and patient. The network provider is solely responsible for the services provided to any covered person.

General Exclusions

Only health care services that are described in the ***Covered Health Services*** section are covered under the Medical Plan. The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, sickness or mental illness does not mean that the procedure or treatment is covered under the Medical Plan.

The following services and supplies are excluded from coverage under the Medical Plan; however, this list may not be exhaustive. For a complete, current list of services and supplies excluded from coverage under the Medical Plan, or to confirm whether a specific service or supply is excluded, call the phone number located on the back of your ID card, or go online at www.bcbsil.com and sign in as a member to view information about your medical coverage.

- Health services, supplies, or hospitalizations that are not covered health services.
- Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.
- Services not performed by an appropriately licensed, certified or otherwise authorized provider pursuant to the law of jurisdiction in which care or treatment is received.
- Services or supplies rendered to you as the result of an injury caused by another person to the extent that you have collected damages for such injury and that the Medical Plan has provided benefits for the services or supplies rendered in connection with such injury.
- Services or supplies that do not meet accepted standards of medical or dental practice including, but not limited to, services which are experimental or investigational in nature.
- Upper and lower jaw bone surgery except for direct treatment of acute traumatic injury or cancer. No coverage is provided for orthognathic surgery or jaw alignment except under the HMO Illinois option.
- Expenses for or related to any eye surgery mainly to correct refractive errors.
- Elective abortions.
- Custodial care; long term care; domiciliary care; respite care; rest cures. (Custodial care means: (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing; or (3) services that do not require continued administration by trained medical personnel.)
- Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
- Health services and associated expenses for cosmetic procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; plastic surgery; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or that are performed as a treatment for acne; radial keratotomy and other refractive eye surgery. Cosmetic procedures are those procedures that improve physical appearance. Reconstructive surgery is surgery that is incidental to an injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. (Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Notify the claims administrator at least five business days before receiving services. By notifying the claims administrator, the claims administrator can verify that the service is a reconstructive procedure rather than cosmetic one.)
- Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

- Replacement of an existing breast implant is excluded. Breast reconstruction following mastectomy for cancer is covered.
- Health services and associated expenses for the surgical treatment and non-surgical, medical treatment of obesity (including morbid obesity) are excluded, except to the extent required by law.
- Experimental, investigational services and unproven services are excluded. The fact that an experimental, investigational service or an unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition. Diagnostic testing that is part of a survey or research study or that is investigational.
- Health services and associated expenses for removal of an organ from a covered person for purposes of transplantation into another person, except as may otherwise be covered by the organ recipient's coverage under the Medical Plan. Health services and associated expenses for transplants involving mechanical or animal organs.
- Health services and associated expenses for organ or tissue transplants are excluded, except those specified as covered in the underlying certificates and program documents for each of the benefit options available under the Medical Plan.
- Any solid organ transplant otherwise covered under the Medical Plan that is performed as a treatment for cancer.
- Health services and associated expenses for megavitamin therapy; psychosurgery; nutritional-based therapy.
- Services or supplies rendered because of behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness.
- Special education therapy such as music therapy or recreational therapy.
- Services and supplies for smoking cessation programs and the treatment of nicotine addiction are excluded, except to the extent required by law.
- Surrogate parenting. Unnecessary amniocentesis. Health services and associated expenses for gender transformation operations, sterilizations, and for reversal of sterilizations.
- Repair or replacement for any otherwise covered implant. Penile implants for the treatment of impotence having a psychological origin.
- Except when needed because of a change in the covered person's medical condition or due to anatomical growth, repair or replacement for any otherwise covered prosthetic or durable medical equipment in whole or in part is excluded. Personal comfort items, including air conditioners and humidifiers, even though prescribed by a physician. Wigs (cranial prostheses) are excluded.
- Growth hormone therapy except as may be provided as a prescription drug benefit for a documented growth hormone deficiency, growth delay due to cranial radiation, or chronic renal disease.
- Charges incurred in connection with the provision or fitting of hearing aids. Charges incurred in connection with the provision or fitting of eye glasses or contact lenses, except as specified as covered in the underlying certificates and program documents for each of the benefit options available under the Medical Plan. Optometric therapy is excluded.
- Routine vision care such as eye refractions, eyeglasses, contact lenses or their fitting except under the HMO Illinois option.
- Hearing aids and/or their fitting; exams for hearing aids; routine hearing exams except under the HMO Illinois option.
- Travel or transportation expenses, even though prescribed by a physician. Ambulance services are covered as described in the underlying certificates and program documents for each of the benefit options available under the Medical Plan.
- Health services for treatment of military service-related disabilities, when the covered person is legally entitled to other coverage and facilities are reasonably available to the covered person.
- Mental health and/or substance abuse services rendered in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental health and/or substance abuse services, when such services extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention. Specifically excluded are health and/or substance abuse services for the treatment of insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.
- Mental health services for the treatment of mental illnesses that will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management

according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorders; and paraphilias.

- Mental health and/or substance abuse services for the following: (1) services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents; and (2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee as medically necessary.
- Marriage counseling.
- Hypnotism.
- Inpatient and Outpatient Private Duty Nursing Service.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.
- Self-management training, education and medical nutrition therapy, except as specifically stated in this SPD.
- Outpatient prescribed or non-prescribed medical supplies including but not limited to elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; over-the-counter drugs and treatments.
- Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments not otherwise covered under the Medical Plan, when such services are: (1) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.
- Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Under the HMO Illinois option, health services not provided by or under the direction of a network physician or other network provider, except health services received at an urgent care center and emergency health services (described in the ***Procedures For Obtaining Health Services*** section) or referral services authorized in advance by the claims administrator (described in the ***Procedures For Obtaining Health Services*** section).
- Services rendered by a provider with the same legal residence as the covered person or who is a member of the covered person's family, including spouse, brother, sister, parent or child.
- Health services otherwise covered under the Medical Plan, but rendered after the date individual coverage under the Medical Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Medical Plan terminates.
- Speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation.
- Treatment received from a clinic maintained by an employer, labor union or a similar group
- Routine foot care, except for persons diagnosed with diabetes or peripheral vascular disease. Treatment and supplies for flat foot conditions.
- Charges for failure to keep an appointment or for completion of a claim form.
- Enteral feedings and other nutritional and electrolyte supplements.
- Health services for which the covered person has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of coverage under the Medical Plan.
- Coverage for an otherwise eligible person or a dependent who is on active military duty (unless otherwise allowed under the Medical Plan); health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion will not apply to you and your dependents, including an expatriate and employee traveling on DePaul business, unless you are in the military or eligible for military service related care.
- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance or similar legislation provided, however, that if a workers' compensation claim is denied, this exclusion shall not be applicable.
- Acupuncture that does not follow the claims administrator’s guidelines, acupressure, hypnotism, Rolfing, massage therapy, aroma therapy, and other forms of alternative treatment.

- Specifically excluded from coverage are appetite suppressants and other weight loss products or programs unless determined to be medically necessary; prescription drug products for tobacco dependency or smoking cessation, except to the extent required by law; medications for cosmetic purposes only; compounded prescription drug products not containing at least one ingredient requiring a prescription order or refill; medication dispensed in excess of the Medical Plan's days' supply limitations; replacement prescription drug products resulting from lost, stolen, broken, or destroyed prescription order or refill; drugs which are prescribed, dispensed or intended for use while the covered person is confined in a hospital, skilled nursing facility, or alternate facility; injectable drugs except when self-administered as defined by the claims administrator or its designee and the drug can be injected subcutaneously or intra-muscularly; blood derivatives not classified as prescription drugs; durable medical equipment that is not specified as covered in the underlying certificates and program documents for each of the benefit options available under the Medical Plan. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies specifically stated as covered; general and injectable vitamins, except prenatal vitamins, vitamins with fluoride, and B-12 injections; unit dose packaging of prescription drug products; Progesterone suppositories; experimental, investigational or unproven services and medications; medication used for experimental, investigational or unproven indications and/or dosage regimens determined by the claims administrator to be experimental, investigational or unproven; prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made provided, however, that if a workers' compensation claim is denied, this exclusion shall not be applicable; drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed and any drug that is therapeutically equivalent to an over-the-counter drug.
- Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements.
- Under the HMO Illinois option, special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated as covered in the underlying certificate and program documents for the HMO Illinois option.
- Any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Special Requirements

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (Newborns' Act) includes important protections for mothers and their newborn children with regard to the length of the hospital stay following childbirth. In accordance with the Newborns' Act, group health plans and health insurance issuers generally may not 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, The Newborns' Act 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).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires the Medical Plan to provide benefits for breast reconstruction following mastectomy for patients who elect reconstruction. Any related services are to be provided in consultation between the patient and the attending physician. Coverage for the following services will be subject to the same deductibles and coinsurance that are applicable to medical and surgical benefits provided under the Medical Plan:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,

- Prosthesis, and
- Treatment of physical complications of all stages of a mastectomy including lymphedemas.

Medical Plan Definitions

This Section defines the terms used throughout this document and is not intended to describe covered or uncovered services. Additional definitions may be available in certificates provided by claims administrators.

Alternate Facility - a non-hospital health care facility, or an attached facility designated as such by a hospital, which provides one or more of the following services on an outpatient basis pursuant to the law of jurisdiction in which treatment is received: prescheduled surgical services, emergency health services, or prescheduled rehabilitative, laboratory or diagnostic services, or inpatient or outpatient mental health services or substance abuse services.

Brand-Name Drug - a prescription drug product is considered a brand-name if it is: (1) manufactured and marketed under a trademark or name by a specific drug manufacturer; and (2) identified as a brand-name product by the claims administrator or its designee.

Chiropractor - any doctor of chiropractic who is duly licensed and qualified to provide chiropractic health services, treatment or care under the law of jurisdiction in which treatment is received.

Confinement/Confined - an uninterrupted stay following formal admission to a hospital, network skilled nursing facility or network inpatient rehabilitation facility.

Congenital Anomaly - a physical developmental defect present at birth.

Coverage or Covered - the entitlement by a covered person to reimbursement for expenses incurred for covered health services under the Medical Plan, subject to the terms, conditions, limitations and exclusions of the Health Plans.

Covered Health Services - those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or symptoms. A covered health service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
  - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
  - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is a cost-effective method that yields a similar outcome to other available alternatives, to the extent such alternatives exist.
- It is not excluded under the ***General Exclusions*** section of this SPD.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described above.

Covered Person - either the employee or an eligible enrolled dependent. References to "you" and "your" throughout this document are references to a covered person.

Durable Medical Equipment - medical equipment that:

- Can withstand repeated use;
- Is not disposable;
- Is used to serve a medical purpose;
- Is generally not useful to a person in the absence of a sickness or injury; and
- Is appropriate for use in the home.

Eligible Charge - (1) in the case of a Provider (other than a Professional Provider) that has a written agreement with the claims administrator to provide care for you at the time Covered Health Services are rendered, such Provider's claim charge for Covered Health Services, and (2) in the case of a Provider (other than a Professional Provider) that does not have a written agreement with the claims administrator to provide care to you at the time Covered Health Services are rendered, the lesser of (a) the Provider's billed charges, or the Eligible Charge determined by the claims administrator, which is developed from the base Medicare reimbursement rate and which represents approximately 100% of the base Medicare reimbursement rate (excluding any Medicare adjustments made based on information provided in the claim).

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustments that are based on information on the claim.

When a Medicare reimbursement rate is not available for a Covered Health Service or is unable to be determined on the information submitted on the claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider's standard billed charge for such Covered Health Service.

The claims administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the claims administrator does not have any claim edits or rules, the claims administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the claims administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Emergency Medical Condition - accidental bodily injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

Emergency Health Service – a health care service or supply that, with respect to an emergency medical condition is:

- a medical screening examination (as required under Section 1867 of the Social Security Act) within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; or
- such further medical examination or treatment, to the extent it is within the capabilities of the staff and facilities available at the hospital, as is required (under Section 1867 of the Social Security Act) to stabilize the patient.

Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness;
- awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to a covered person; and
- specifically with respect to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to the covered person.

Formulary Drug – a brand name prescription drug that has been designated as a preferred drug by the claims administrator.

Generic Drug – a prescription drug product that is:

- Chemically equivalent to a brand-name drug whose patent has expired; and
- Identified as a generic drug by the claims administrator or its designee.

Health Services - the health care services and supplies covered under the Medical Plan, except to the extent that such health care services and supplies are limited or excluded.

Home Health Agency - a program or entity that provides an organized skilled patient care program in which care is provided in the home. Care may be provided by a hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require skilled nursing service on an intermittent basis under the direction of your physician. This program includes skilled nursing service by a registered professional nurse, the services of physical, occupational and speech therapists, hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for private duty nursing service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.)

Hospice Care - a centrally administered program designed to provide physical, psychological, social and spiritual care for terminally ill persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice care program services are available in the home, or in in-patient hospital or skilled nursing facility special hospice care units.

Hospital - an institution, operated pursuant to law, that:

- Is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of physicians;
- Has 24-hour nursing services; and
- Is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations or by the American Osteopathic Hospital Association.

A hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a hospital or a special unit of a hospital designated as an inpatient rehabilitation facility which provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis pursuant to the law of jurisdiction in which treatment is received.

Medical Care – the ordinary and usual professional services rendered by a physician, or other specified provider during a professional visit, for the treatment of an illness or injury.

Medically Necessary - (including but not limited to mental health and substance abuse services, outpatient prescription drug products at participating pharmacies, and mail service prescription drugs) health care services and supplies that are determined by the claims administrator, to be:

- Medically appropriate;
- Necessary to meet the basic health needs of the covered person;
- Rendered in a cost-efficient manner and in a setting appropriate for the delivery of the service;
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the claims administrator;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician; and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - Safe with promising efficacy:
    - For treating a life threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

    For the purpose of this definition, the term "life threatening" is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean that it is a medically necessary covered health service as defined in this document. The definition of medically necessary used in this document relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.

Medicare - Part A, Part B, and Part D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health/Substance Abuse Designee - the organization or entity which provides or arranges covered mental health services and substance abuse services.

Mental Health Services - those services and supplies covered under the Medical Plan for the diagnosis and treatment of mental illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is covered.

Mental Illness - defined for the purpose of the Medical Plan as those mental health or psychiatric diagnostic categories of the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless specifically excluded from coverage.

Network - when used to describe a provider of health services (such as a hospital, physician, alternate facility, home health agency, skilled nursing facility, or inpatient rehabilitation facility) means that the provider has a participation agreement in effect to provide health services to covered persons. The participation status of providers may change from time to time.

Participating IPA – any duly organized Individual Practice Association of physicians which has a contract or agreement with HMO Illinois to provide professional and ancillary services to persons enrolled under this benefit option.

Participating Medical Group – any duly organized group of physicians which has a contract or agreement with HMO Illinois to provide professional and ancillary services to persons enrolled under this benefit option.

Participating Pharmacy - a pharmacy that has:

- Entered into an agreement to provide prescription drugs to covered persons;
- Agreed to accept specified reimbursement rates for dispensing prescription drug products; and
- Been designated by the claims administrator as a participating pharmacy.

A participating pharmacy can be either a retail or a mail service pharmacy.

Physician - any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Pregnancy - includes prenatal and postnatal care, childbirth, and any complications associated with Pregnancy.

Prescription Drug Cost - the contracted reimbursement rate, including any sales tax, with the participating pharmacy where a prescription drug product is dispensed. The prescription drug cost does not include any manufacturer's refunds or incentive payments which may be received by and will be retained by the Plan Sponsor or the Plan Administrator.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order or refill. For the purpose of coverage under the Medical Plan, this definition includes insulin and the following diabetic supplies: insulin syringes with needles; blood testing strips - glucose; urine testing strips - glucose; ketone testing strips and tablets; lancets and lancet devices.

Prescription Order or Refill - the directive to dispense a prescription drug product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Primary Care Physician - a network physician selected by a covered person to be responsible for providing or coordinating all covered health services which are covered under the Medical Plan as network benefits. A primary physician has entered into an agreement to provide primary care health services to covered persons. His or her practice predominately includes pediatrics, internal medicine, gynecology, obstetrics, family, or general practice.

Private Duty Nursing – skilled nursing services provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private duty nursing services do not include custodial care services.

Provider - a physician, hospital, skilled nursing facility, home health agency, hospice, pharmacy or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of

jurisdiction in which care or treatment is received. Whether or not a specific provider “type” or “class” such as LCSW, APN, NCC, LMFT, etc. is covered under the Medical Plan is determined by the claims administrator’s standard procedure or policy and may change from time to time.

Reconstructive Surgery - surgery which is incidental to an injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

Semi-Private Room - a room with two or more beds. The difference in cost between a semi-private room and a private room is covered only when a private room is determined to be necessary or when a semi-private room is not available.

Sickness - physical illness, disease or pregnancy. The term "sickness" as used in this summary does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

Skilled Care Services - skilled nursing and skilled rehabilitation services that meet all of the following criteria:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- Are ordered by a physician; and
- Are considered covered health services for the treatment of the sickness, injury or pregnancy.

Determination of benefits for skilled care services is made based on both the skilled nature of the service and the need for physician-directed medical management. Skilled care services are not determined by the availability of caregivers to perform them; the absence of a person to perform an unskilled service does not cause the service to become "skilled".

Skilled Nursing Facility - an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative in-patient care and is duly licensed by the appropriate governmental authority to provide such services.

Standing Referral – a written referral from your Primary Care Physician or Woman’s Principal Health Care Provider for an ongoing course of treatment pursuant to a treatment plan specifying needed services and time frames as determined by your Primary Care Physician or Woman’s Principal Health Care Provider, the consulting physician or provider and HMO Illinois.

Substance Abuse Services - services and supplies covered under the Medical Plan for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless specifically excluded from coverage under the Medical Plan. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is covered.

Surgery – the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the claims administrator.

Unproven Services - services that are not consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Urgent Care Center - a non-hospital-based facility that provides health services that are required in order to prevent serious deterioration of a covered person's health and that are required as a result of an unforeseen sickness, injury, or onset of threatening symptoms.

Woman's Principal Health Care Provider- physician licensed to practice medicine in all of its branches, specializing in obstetrics or gynecology or specializing in family practice.

DENTAL PLAN DETAILS

Introduction

This section of the Summary Plan Description describes the coverage provided under the DePaul University Dental Program (the "Dental Plan") and explains your benefits, including specific details about which services and providers are covered under the Dental Plan.

The Dental Plan helps you and your family maintain good dental health. The Dental Plan encourages preventive care of your teeth and gums by paying 100% of the reasonable, customary cost of routine cleanings and examinations, twice per calendar year. The Dental Plan also provides benefits for necessary primary care or major care, as described in more detail below, as well as orthodontic benefits for your eligible dependent children.

The Dental Plan includes a network of providers, administered by Blue Cross Blue Shield. If you use a network dentist, he or she will charge a discounted rate so that you and DePaul will save money. You are always free to use a non-network provider; however, if you do so, you may pay more out-of-pocket because the non-network provider may charge more than a network dentist charges. For a complete list of providers in the dental network, visit www.bcbsil.com/member/dental/dppo_provider_finder.htm.

You may also contact BCBS customer service for more information regarding your benefits or to locate a provider within the network. Customer service can be reached at 800-367-6401. Representatives are available from 8:00 a.m. to 6:00 p.m., Central Time, Monday through Friday.

Dental Plan-at-a-Glance

Plan Provision	Key Information & Highlights
Annual Deductible	$50 per person – If you have family coverage, the first three members of your family to receive services will be subject to a $50 deductible, per person, per benefit period.
Preventive Services	Plan pays 100%* without regard to whether the deductible has been satisfied.
Primary Services	Plan pays 80%* after the deductible.
Major Services	Plan pays 50%* after the deductible.
Orthodontic Services (for dependents under age 19)	Plan pays 50%* without regard to whether the deductible has been satisfied.
Emergency Dental Services	Plan pays 100%* after the deductible.
Maximum Benefit	$1,500 per calendar year, per person (excludes orthodontic services)
Maximum Benefit – Orthodontic Services	$1,500 lifetime maximum
Claims Administrator	Blue Cross Blue Shield

*The Plan pays a percentage of the "maximum allowance," meaning the amount that network dentists agree to accept as payment in full, for a particular service.

Dental Plan Coverage

Deductibles
The deductible is the amount you pay each calendar year before the Dental Plan begins to pay benefits. The deductible is $50 per person for primary and major dental services. Preventive dental services and orthodontics are not subject to the deductible.

Family Deductible
If you have family coverage and three covered family members have each satisfied their individual $50 deductible for a calendar year, no one else in your family will have to meet a deductible during that calendar year in order for benefits to be paid.

Covered Services
The following is a summary of covered services under the Dental Plan. For more detailed descriptions and explanations of benefits, please refer to the certificate of coverage for the Dental Plan, which you may obtain by either signing in as a member at www.bcbsil.com and selecting "View Medical Coverage," or bby contacting the Benefits Department.

Your dental benefits cover the following services, so long as the services are provided by a dentist, physician or dental hygienist. Dental services are divided into four categories, each with different levels of payment:

- preventive
- primary
- major
- orthodontics

The Dental Plan pays a percentage of your covered expenses, based on the amount of the maximum allowance for a particular service.

If you receive treatment from a provider that participates in the Dental Plan network, the provider will charge only up to the amount of the maximum allowance. You will therefore be responsible for paying only your deductible (if you have not yet met your deductible for the plan year) and the difference between the maximum allowance and the percentage paid by the Dental Plan.

If you receive treatment from a provider that does not participate in the Dental Plan network, the provider may charge more than the amount of the maximum allowance for a particular service. You will be responsible for paying your deductible (if you have not yet met your deductible for the plan year) and the difference between the amount charged by the provider and the percentage paid by the Dental Plan (which is a percentage based on the maximum allowance amount).

Maximum Benefits
The Dental Plan pays up to $1,500 in benefits for each covered person every calendar year.

Orthodontic services have a separate lifetime maximum of $1,500 for each covered person.

Preventive Services
Preventive services are paid at 100% of the maximum allowance and are not subject to the deductible.

Preventive services include:

- oral examinations – two per plan year
- cleaning, scaling and polishing of the teeth – twice per plan year
- topical fluoride application – one application twice per plan year, for each covered dependent up to age 19
- sealants for dependent children under age 19

- dental x-rays
  - panoramic and routine full-mouth x-rays – one full-mouth series every thirty-six (36) months
  - routine bitewing x-rays – one set per plan year

Emergency Dental Services
Emergency oral examinations and treatment for the relief of pain are paid at 100% of the maximum allowance, after you have met your deductible.

Primary Dental Services
Primary dental services are paid at 80% of the maximum allowance, after you have met your deductible.

Primary dental services include:

- fillings
- pin retention
- composites
- simple extractions – unless specifically excluded
- oral surgery
- temporary (stainless steel) crowns
- endodontics – including root canal therapy, pulp cap, apicoectomies, apexification, retrograde filling, hemisection, therapeutic pulpotomy, pulpal debridement
- pulp vitality tests
- biopsies of oral tissue
- repair of removable dentures
- recementing of crowns, inlays and bridges
- periodontics – including: gingivectomy/gingivoplasty (one full mouth treatment per plan year), gingival curettage, periodontal scaling and root planing, full mouth debridement, osseous surgery, osseous grafts, skin grafts, and periodontal maintenance procedures (twice per plan year)
- oral surgery services – including surgical tooth extraction, alveoloplasty, vestibuloplasty, and other necessary dental surgical procedures
- space maintainers – covered only for dependents under the age of 19, provided such space maintainers are not part of orthodontic treatment
- general anesthesia – covered only if administered in connection with a covered dental procedure, by a person who is licensed to administer general anesthesia and is not the dentist who performed the dental procedure

Major Dental Services
Major dental services are paid at 50% of the maximum allowance, after you have met your deductible.

Major dental services include:

- inlays, onlays and crowns (except for temporary crowns)
- bridges
- bridge repair
- full and partial dentures
- denture adjustments and relining – during the first six months after obtaining dentures or having them repaired, adjustments are covered only if they are done by a provider other than providers in the dentist's office that originally provided or repaired the dentures
- addition of tooth or clasp

Once you receive benefits for a crown, bridge or full/partial dentures, replacements are not covered until five years have elapsed. Also, benefits are not available for the replacement of a bridge or denture that could have been repaired.

Orthodontic Services
Orthodontic services are paid at 50% of the maximum allowance and are not subject to the deductible. Benefits are available only for covered dependents who are under the age of 19 and will end at the end of the month in which a covered dependent reaches the age of 19.

Orthodontic services include:

- diagnostic services – including examination, study models, x-rays and all other diagnostic aids – coverage for diagnostic services is limited to once in any five-year period, beginning with the date of the first diagnostic examination
- active orthodontic treatment
- retention treatment

Benefits are not payable for the replacement or repair of any appliance used during orthodontic treatment.

Alternative Treatment

In all cases in which more than one course of treatment is possible, the benefit payment will be based on the least costly course of treatment.

Pre-Certification of Benefits

If your dentist recommends a course of treatment that will cost more than $300, you should request that he or she submit a claim form to BCBS before treatment begins. The claim form must include:

- a description of the planned treatment;
- copies of necessary x-rays, photographs and models; and
- an estimate of the charges for the treatment.

BCBS will review the report and materials, taking into consideration alternative courses of treatment, and will notify you and your dentist of the estimated benefits that will be payable for your treatment. This is not a guarantee of payment, but an estimate of benefits available for the proposed services.

Care by More than One Dentist

If you change dentists in the middle of a course of treatment, benefits will be provided as if you had stayed with the same dentist until your treatment was completed. There will be no duplication of benefits.

Services Not Covered

The Dental Plan does not cover the following services and supplies:

- dental procedures that are not medically necessary
- treatment that is not specifically mentioned in the plan booklet
- hospital care
- treatment for an injury or illness that is payable under Workers' Compensation or a similar statute
- treatment that is provided by or is available from local, state or federal government (for example, Medicare), whether or not benefits are actually received – except as otherwise provided by law
- services or supplies for any illness or injury that occurs as a result of war or act of war, on or after the start of your coverage under the Dental Plan
- treatment that does not meet accepted standards of medical or dental practice including, but not limited to, services that are investigational in nature
- cosmetic surgery and related services and supplies
- treatment for which you would not be required to make payment if you did not have this or similar coverage
- charges for failure to keep a scheduled visit
- charges for completion of a claim form
- implants and their associated services
- dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction (TMJ) and related disorders
- certain types of oral surgery:
  - related to a congenital malformation
  - for the excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth
  - for the excision of exotoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses)
  - for treatment of fractures of facial bone

- for external incision and drainage of cellulitis
- for incision of accessory sinuses, salivary glands or ducts
- for reduction of dislocation, or excision of, the temporomandibular joints
- for removal of completely bony impacted teeth

- services that are performed due to an accidental injury that is caused by external force
- any services, treatments or supplies included as an eligible benefit under any other group hospital, medical or surgical coverage

Dental Plan Definitions

Course of Treatment – any number of dental procedures or treatments performed by a dentist or physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined

Crown – a restoration that replaces enamel, covering the entire crown of the tooth, usually made of porcelain or acrylic

Full Denture – artificial teeth replacing all teeth in an arch (may be upper or lower)

Maximum Allowance – the amount determined by Blue Cross Blue Shield, that participating dentists have agreed to accept as payment in full for a particular dental covered service

Partial Denture – an appliance supporting artificial teeth less than the full number of teeth in one jaw

Periodontal – treating of disease of the gum and tissues surrounding teeth

Space Maintainers – appliances to prevent adjacent teeth from moving into space left by a lost tooth

VISION PLAN DETAILS

Introduction

This section of the Summary Plan Description describes the coverage provided under the DePaul University Vision Plan (the "Vision Plan") and explains your benefits, including specific details about which services and providers are covered under the Vision Plan.

Vision Plan-at-a-Glance

The Vision Plan pays greater benefits when you use a provider who is part of the nationwide Vision Service Plan ("VSP") network. You are eligible for a reduced benefit when you use a non-VSP provider, subject to a maximum reimbursement schedule. The Vision Plan pays benefits for an eye exam and either one pair of prescription eyeglasses (including both lenses and frames) or one pair of contacts but not both, once every plan year.

Access to Vision Plan Information Online

For more detailed information about your vision benefits, or to obtain a copy of VSP's Network Doctor Directory, contact VSP's customer service department at 800-877-7195, or you can find more information on VSP's website at www.vsp.com. The first time you access the VSP website, you will need to create a member login ID. To create a member login ID, select "Members," then select "Don't Have a User ID or Password? Register Now." From there, follow the instructions to create your member login ID.

Once you have created your member login ID, you may access information about your Vision Plan benefits online by visiting www.vsp.com and selecting "Members." Once you have signed in as a member, you should click on either "Benefits Overview" or "Benefits Detail" for more information.

VSP Network Benefits

To receive the maximum benefits offered under the Vision Plan, your VSP network provider must obtain authorization from VSP prior to treating you. If your VSP network provider does not obtain authorization, then you will be responsible for payment as if you had chosen a non-network provider (see ***VSP Non-Network Benefits*** below). To ensure that your VSP network provider obtains the necessary authorization, you should identify yourself as covered by the Vision Plan when you schedule your appointment with a VSP network provider.

If you go to a VSP network provider (and the provider obtains benefit authorization before providing services), the Vision Plan will pay for the following, according to the limitations described below. You may receive benefits for only one pair of eyeglasses (lenses and frames) or one pair of contacts in each plan year.

- **Routine Eye Exam** – You are responsible for a $10 co-pay. Benefits for a routine eye exam are available once each plan year.

- **Eyeglasses** – You are responsible for a $20 co-pay (applies to purchase of lenses and frames). Benefits for one pair of eyeglasses are available once each plan year.
  - Prescription lenses – Your eyeglasses may contain one of the following types of lenses covered under the Vision Plan:
    - single vision
    - bifocal
    - trifocal
    - lenticular

    The Vision Plan will also provide benefits for the cost of using tinted/photochromic lenses for your eyeglasses.

- Frames – VSP will reimburse you for up to $150 towards the cost of the frames you select for your eyeglasses (after the $20 co-pay for your eyeglasses).
    - If you choose frames above the allowance, you will be responsible for the remaining out-of-pocket cost of your frames, subject to the discount described below.
    - Your frame allowance for the plan year may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.
- You will receive a 20% discount on the cost of non-covered materials purchased in connection with your covered eyeglasses, when you purchase your eyeglasses from a VSP Network Provider.
    - The discount is available in connection with your purchase of eyeglasses within 12 months following the date of your last eye exam.
    - The discount applies to non-covered materials such as ultra-violet, scratch-resistant and anti-reflective coatings on the lenses in your eyeglasses.
    - The discount also applies to the remaining out-of-pocket cost of your frames, if you choose frames that exceed the plan allowance.
    - The discount does not apply to items such as contact lens solution, eyeglasses cases, cleaning products, or repairs of lenses or frames.
    - To the extent the discount is prohibited by the manufacturer, the discount will not apply.

- **Second Pair of Eyeglasses** – You will receive a 20% discount if you purchase a second complete pair of prescription glasses (lenses and frame) or prescription sunglasses from the VSP network provider.

- **Contact Lenses** – Benefits for <u>either</u> one set of necessary contact lenses, <u>or</u> one set of elective contact lenses, are available once each plan year.
    - Necessary Contact Lenses – You are responsible for a $20 co-pay.
        - Necessary contact lenses are available as a benefit when specific criteria are satisfied and when such contact lenses are prescribed by your vision care provider. Contact VSP for more information.
    - Elective Contact Lenses – There is no co-pay for elective contact lenses.
        - Allowance – The Vision Plan provides an allowance of $150 for the cost of elective contact lenses.
    - Discount on Exam – You will also receive a 15% discount on the cost of your contact lens exam and fitting at a VSP network provider.

- **Low Vision Services** – You are responsible for a $10 co-pay.
    - If you have severe visual problems that are not correctable with regular lenses, the following benefits are available:
        - Supplemental Testing – Includes evaluation, diagnosis and prescription for vision aids where indicated.
        - Supplemental Aids – The Vision Plan will pay 75% of the cost of supplemental aids, up to a maximum amount of $1,000.
    - In no event will the Vision Plan pay more than $1,000 for low vision benefits, including supplemental testing <u>and</u> supplemental aids, in the course of two benefit periods (i.e., two years).

VSP Non-Network Benefits

The Vision Plan reimburses a portion of the cost for services and eyewear, after the required co-pay, if you choose to go to a non-VSP network provider. The co-pay for a routine eye exam is $10, and the co-pay for eyeglasses (applies to purchase of lenses and frames) or necessary contact lenses is $20. You may receive benefits for only one pair of eyeglasses or one pair of contacts in each plan year.

Additionally, if you decide to see a non-VSP network provider, you will be required to pay the provider in full at the time of your appointment and submit a claim to VSP for reimbursement of covered expenses, up to the amount specified for the service in the reimbursement schedule below.

Reimbursement Schedule for Benefits Obtained from VSP Non-Network Providers

Type of Service or Eyewear	Maximum Reimbursement Amount
Eye Exam	$45, once each plan year
Frames*	$70, once each plan year
Lenses: The maximum reimbursement amount for lenses varies based on the type of lenses selected.	As described below, for one set of lenses each plan year
Single-Vision Lenses	$30
Lined Bifocal Lenses	$50
Lined Trifocal Lenses	$65
Lenticular Lenses	$100
Lens Options	As described below, once each plan year
Tinted/Photochromic	$5
Contact Lenses:	As described below, for one set of contact lenses (in lieu of eyeglasses) once each plan year
Necessary Contact Lenses	$210
Elective Contact Lenses	$105
Low Vision Services**	As described below
Supplemental Testing	$125
Supplemental Aids	75% of cost, up to a maximum amount of $1,000

*The frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.

**In no event will the Vision Plan pay more than $1,000 for low vision benefits, including supplemental testing and supplemental aids, in the course of two benefit periods (i.e., two years).

Non-Covered Lens Options

If you select any of the following options for your lenses, the Vision Plan will pay the basic cost of the allowed lenses, and you will pay any additional costs for the options you choose:

- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminated lenses;
- Oversize lenses;

- Polycarbonate lenses;
- Progressive multifocal lenses; and
- Ultraviolet protected lenses.

General Exclusions

The following services and materials are excluded from coverage under the Vision Plan:

- Orthoptics or vision training and any associated supplemental testing;
- Corneal Refractive Therapy (CRT);
- Orthokeratology;
- Refitting of contact lenses after the initial 90-day fitting period;
- Plano lenses;
- Two pairs of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under the Vision Plan that are lost or broken, except at normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Plano contact lenses to change eye color cosmetically;
- Artistically-painted contact lenses;
- Contact lens insurance policies or service contracts;
- Additional office visits associated with contact lens pathology;
- Contact lens modification, polishing or cleaning;
- Costs for services and/or materials exceeding Plan Benefit allowances;
- Services or materials of a cosmetic nature; and
- Services and/or materials not indicated under the Vision Plan as covered benefits.

Diabetic Eye Care Program

The Vision Plan includes benefits under the Diabetic Eyecare Program ("DEP") for participants who have been diagnosed with type 1 diabetes and specific ophthalmological conditions. The DEP allows a participant's VSP network provider to provide certain diagnostic services, but it does not cover medical treatment for participants with diabetic or other medical conditions.

Obtaining Diagnostic Services under the Diabetic Eyecare Program

You do not need to obtain special authorization or a referral in order to receive benefits under the DEP. The diagnostic services covered by the DEP will be provided by your VSP network provider, as needed, following your routine eye examination. The services listed below are covered by the DEP, if you go to a VSP network provider. Certain benefits may be covered if you go to a non-VSP network provider. You should contact VSP at 800-877-7195, or visit VSP's website at http://www.vsp.com, login as a member, and select "Benefits Overview" or "Benefits Detail" for more information.

Services Covered by the DEP

Service	Co-Pay	Frequency
Ophthalmogical Services and Office Visit	$5	Once each plan year
Gonioscopy (use of a special contact lens to look at the eye's aqueous drainage area)	No additional co-pay	Once each plan year
Extended Ophthalmoscopy (method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan)	No additional co-pay	Once every six months
Fundus Photography (taking photos of the inside of the eye that show the optic nerve and retinal vessels)	No additional co-pay	Once every six months

RECEIVING YOUR BENEFITS – CLAIMS PROCEDURES

To receive your benefits under the Health Plans, either you or your provider must file a claim. When a specific claim form is required, you can get the form online through the Human Resources website at https://hr.depaul.edu, or you can contact the Benefits Department directly to request the form.

Time Limits for Filing Claims

There is a limit on the amount of time you have to file claims. The time limit may vary depending on the benefit option, as outlined below:

- Dental Claims – File your claim within 365 days of the date of service.
- Vision Claims – File your claim within 180 days of the date of service.
- Medical Claims – File your claim by the December 31st of the year following the year in which the services were received.
- Prescription Drug Claims – File your claim within 365 days of the date of service.

If you file your claim after the deadline, it will not be considered an eligible expense and will not be paid. If you file a claim for benefits and it is denied, you may appeal your claim. See ***How to Appeal if Your Claim Is Denied***.

Claims Related to Eligibility

Claims that relate solely to whether you are eligible to participate in the Health Plans, and that do not involve a claim for benefits under the Health Plans, are reviewed by the Benefits Department. All decisions made by the Benefits Department are final and binding.

Claims Related to Benefits

Claims that relate to benefits under the Health Plans, including a claim for benefits that requires an eligibility determination in order to determine whether an individual may receive benefits under the Health Plans, should be made to the proper claims administrator in accordance with the Health Plans' claims filing procedures as described below.

Claims Administrators

- Medical Plan and Dental Plan – Benefit claims and appeals under the Medical Plan and the Dental Plan are decided by Blue Cross and Blue Shield of Illinois, subject to the procedures described below.
- Vision Plan – Benefits claims and appeals under the Vision Plan are decided by Vision Service Plan.

The claims administrators have been delegated the discretionary authority to grant or deny benefits under the applicable health plan described in this Section. Benefits under the Health Plans will be paid only if the applicable claims administrator decides in its discretion that the applicant is entitled to them.

Submitting Claims – BlueEdge CDHP Option and PPO Option

For benefits under the BlueEdge CDHP option and the PPO option, network providers are responsible for submitting claims directly to BCBS. In the event a network provider bills you for eligible expenses, you should contact BCBS.

In addition, most hospitals in Illinois will file your claim directly with BCBS. Once BCBS receives your claim, it will process the claim and send payment directly to the hospital. You will receive a statement telling you how much was paid.

If you do not use a network provider (or if you receive services at a hospital that does not file your claim directly to BCBS), you may have to file your own claim. If this is the case, you will need to send BCBS a completed claim form, including the following:

- an itemized bill from the hospital or other provider, with the following information:
  - provider's name and address;
  - diagnosis;
  - date of service;
  - description of service;
  - patient's name, age and sex; and
  - your name and BCBS identification number.

Completed claim forms with attachments should be mailed to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

If your claim relates to benefits for outpatient prescription drugs, send completed claim forms with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 14624
Lexington, KY 40512-4624

Submitting Claims – HMO Illinois Option

For benefits under the HMO Illinois option, you do not need to file a claim for benefits with HMO Illinois when you receive care from one of the following providers:

- your Primary Care Physician;
- a Provider who is affiliated with your Participating Individual Practice Association (IPA) or Participating Medical Group; or
- your Woman's Principal Health Care Provider.

All you have to do is show your ID card to your provider. However, to receive benefits for care from another physician or provider, you must be referred to that provider by your PCP or Woman's Principal Health Care Provider.

When you receive care from providers outside of your Participating IPA or Participating Medical Group (i.e. emergency health services, medical supplies), usually all you have to do to receive your benefits under the HMO Illinois option is to show your ID card to the provider. Claim filing will typically be handled by the provider.

In some situations, you may need to file a claim yourself (for example, if a provider will not file one for you). To do so, you will need to send a completed claim form, including the following, to HMO Illinois:

- an itemized bill from the hospital, physician or other provider, including the following information:
  - provider's name and address,
  - patient's name,
  - diagnosis,
  - date of service,
  - description of the service (including CPT code), and
  - claim charge;
- the eligible employee's name and ID number;
- the patient's name, age and sex; and
- any additional relevant information.

Completed claim forms with attachments should be mailed to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

If your claim relates to benefits for outpatient prescription drugs, send completed claim forms with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 64812
St. Paul, MN 55164-0812

Subject to your written authorization, all or a portion of any eligible expenses due may be paid directly to the provider of the health services instead of being paid to you. However, if your claim is for services rendered by a provider outside of your Participating IPA or Participating Medical Group, you will be reimbursed directly. You will then be responsible for reimbursing the provider.

Submitting Claims – Generally

The claims administrator will process the claim and send you an Explanation of Benefits (EOB), which will detail the amounts covered and paid to the appropriate providers. If you have paid the provider and are to be reimbursed from the claims administrator, your claim must include proof of payment.

You will be responsible for paying to the provider any amounts not covered under the Health Plans.

Claims fall into one of four categories: post-service, pre-service, urgent care and concurrent. Claims for Health Plans benefits will be administered by the appropriate claims administrator (see the ***Health Care Claim and Appeal Phone Numbers and Addresses*** table at the end of this section).

Post-Service Claims

Post-service claims are claims for benefits that are filed after health care has been received. If your post-service claim is denied, you will receive a written notice from the benefit program's claims administrator no later than 30 days after the claim was received, as long as all needed information was provided with the claim. Sometimes additional time is necessary to process a claim due to circumstances beyond the control of the Health Plans. If an extension is necessary, the claims administrator will notify you in writing within the 30-day period of the reasons for the extension and the date by which it expects to render a decision. The extension generally will be no longer than 15 days, unless additional information is needed.

If the extension is necessary because you failed to provide all needed information, the notice of the extension will describe the additional information required. You will have 45 days to provide the additional information, and the time for deciding the claim will be tolled until you provide the requested information. If you do not provide the needed information within the 45-day period, the claims administrator may deny the claim.

Pre-Service Claims

Pre-service claims are claims that require notification or approval prior to receiving health care (for example, in-patient hospital services, or a transplant).

If you file a pre-service claim that does not meet the Health Plans' procedures, the claims administrator will notify you within 5 days. The notice will tell you how to correct the improperly filed claim. This notification may be oral, unless you request a written notification.

If your pre-service claim is submitted properly with all the information necessary, the health program's claims administrator will send you a notice of the benefit determination, whether denied or not, no later than 15 days after it receives the claim. If an extension is necessary to process your pre-service claim due to circumstances beyond the control of the Health Plans, the claims administrator will notify you in writing within the initial 15-day response period, and may request a one-time extension up to 15 days. If

the extension is necessary because you failed to provide all needed information, the notice of the extension will describe the additional information required. You will have 45 days to provide the additional information, and the time for deciding the claim will be tolled until you provide the requested information. If you do not provide the needed information within the 45-day period, the claims administrator may deny the claim.

Urgent Care Claims

Urgent care claims are pre-service claims that require notification or approval prior to receiving medical care and a delay in the care:

- could seriously jeopardize your life, health or your ability to regain maximum function, or
- in the opinion of a physician with knowledge of your medical condition, could cause severe pain that could not be adequately managed without the care or treatment.

If you file an urgent care claim in accordance with the Health Plans' procedures and include all needed information, the health program's claims administrator will notify you of the determination, whether denied or not, as soon as possible, but no later than 72 hours after receipt of the claim.

However, if you file an urgent care claim that does not meet the Health Plans' procedures, the claims administrator will notify you within 24 hours. The notice will tell you how to correct the improperly filed claim. This notification may be oral, unless you request a written notification.

If you fail to provide all the information required to decide your urgent care claim, the claims administrator will notify you that additional information is needed within 24 hours. You will then have 48 hours to provide the requested information.

You will be notified of the determination on your claim no more than 48 hours after the earlier of:
- the claims administrator's receipt of the requested information, or
- the end of the 48 hours given to you to provide the requested information.

Concurrent Care Claims

There are two types of concurrent care claims:

- a claim to extend coverage for a course of treatment beyond a previously approved period of time or number of treatments; or
- a claim regarding reduction or termination of coverage by the Health Plans before the end of a previously approved period of time or number of treatments.

You must submit a request to extend an ongoing course of treatment at least 24 hours before the end of the previously approved limit. If your request for extension is timely and involves urgent care, the health program's claims administrator will notify you of the determination, whether denied or not, within 24 hours after the claim is received. If your claim is not made at least 24 hours prior to the end of the previously approved limit, the request will be treated as an urgent care claim (not a concurrent care claim) and decided according to the timeframes described under ***Urgent Care Claims*****.**

A request to extend coverage that does not involve urgent care will be considered a new claim and will be decided according to the post-service or pre-service timeframes described previously, whichever applies.

If a previously approved ongoing course of treatment is reduced or terminated by the Health Plans, the claims administrator will notify you sufficiently in advance to allow you to submit an appeal before the treatment is reduced or terminated.

Explanation of Denied Health Plan Claims

If your claim for benefits under the Health Plans is denied, the written explanation of the denial will:

- give the specific reason(s) for the denial and cite the applicable Health Plans provisions on which the denial is based;
- describe any additional material or information necessary to perfect the claim and explain why such information is necessary;
- describe the Health Plans' appeal procedures, including the applicable time limits;
- for urgent care claims, describe the expedited review process applicable to such claims;
- disclose any internal rule, guideline, protocol, or similar criterion relied on in denying the claim (or a statement that such information will be provided free of charge upon request); and
- if the denial is based on a medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment relied on for the determination (or include a statement that such explanation will be provided free of charge upon request).

Notifications regarding urgent care claim determinations may be oral, in which case written or electronic (via e-mail) confirmation will follow within three days.

Additional Details Regarding Medical Plan Claims Denials

If your claim for benefits under the Medical Plan is denied, the written explanation of the denial will, in addition to the information listed above:

- include information that allows you to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable));
- include a statement describing the availability of the relevant diagnosis and treatment codes and their corresponding meanings (if you request this information, it will be provided to you as soon as practicable following your request);
- provide the code assigned to the reason for the denial, the meaning of the code, and a description of the standard that was used in denying the claim (if any);
- describe the internal appeals procedures and external review processes for Medical Plan benefits, including information about how to initiate an appeal; and
- include contact information for any applicable office of health insurance consumer assistance or ombudsman that is available to help you with the appeals process.

Questions about Benefit Determinations

If you have questions or concerns about a benefit determination, you may informally contact the claims administrator before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your questions in writing. Remember, however, that if you are not satisfied with a benefit determination, you may appeal it immediately as described in the section that follows, without first informally contacting customer service.

The customer service number is shown on your health program option ID card or in the ***Health Care Claim and Appeal Phone Numbers and Addresses*** table at the end of this section.

HOW TO APPEAL IF YOUR CLAIM IS DENIED

If you submit a claim for benefits and your claim is denied, you have the right to appeal your claim. If you appeal a denied claim for benefits, you can obtain reasonable access to and copies of all documents, records and other information relevant to the claim, upon request and free of charge. Participants in the HMO Illinois option may be charged by their medical group for copies of medical records. You may therefore wish to direct HMO Illinois to request copies of medical records from the medical group directly.

If you disagree with a benefit determination, you (or any person you choose to represent you) may file a written appeal with the claims administrator. Except for appeals involving urgent care (see ***Urgent Care Claims***), or appeals to HMO Illinois, all appeals must be in writing. You will be informed when and where to direct an appeal when your initial claim is denied. You may submit comments, documents, and other information in support of your appeal. The review of the appeal will take into account any information you submit, even if it was not submitted or considered as part of the initial determination.

DePaul has delegated full discretion, authority, and fiduciary responsibility for claims and appeals decisions to the claims administrators for the Health Plans, excluding issues of eligibility which will be decided by the Benefits Department.

Your Deadline to Appeal a Health Care Claim

You have 180 days from receipt of the notice of a claim denial to file an appeal. Your request for appeal should include the following:

- the patient's name and identification number as shown on the program option ID card;
- the date of the medical service;
- the provider's name;
- the reason you believe the claim should be paid; and
- any documentation or other written information to support your request for claim payment.

First Level Appeals

The review of the first level will afford no deference to the initial benefit determination. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the first level appeal.

If your initial claim was denied based on a medical judgment (such as whether a service or supply is experimental or medically necessary), the Health Plans' claims administrator will consult with a health care professional with appropriate training and experience. The health care professional consulted for the first level appeal will not be the professional (if any) who was consulted for the initial claim determination or a subordinate of such professional. The claims administrator also will identify, at your request, medical or vocational experts whose advice was obtained on behalf of the Health Plans in connection with the denied benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

The claims administrator or appeals committee, as applicable, will provide you written or electronic (via e-mail) notification of the determination as follows:

- For first level appeals of pre-service claims, no later than 15 days after receipt of your request for a first level appeal.
- For first level appeals of post-service claims, no later than 30 days after receipt of your request for a first level appeal.

Special Note for Clinical Appeals for HMO Illinois Participants

Upon receipt of a non-urgent pre-service or post-service clinical appeal, HMO Illinois will notify the party filing the appeal within three business days if additional information is needed to review the appeal. Additional information must be submitted within five calendar days of request. HMO Illinois shall render a determination on the appeal within 15 business days after it receives the requested information.

Urgent Care Appeals

If your appeal involves urgent care (as defined above in ***Urgent Care Claims***), the appeal does not need to be submitted in writing. You or your physician should call the claims administrator for urgent care appeals, at the number indicated on your program option ID card, as soon as possible.

The claims administrator will provide you written or electronic (via e-mail) notification of the determination as soon as possible, but in no event later than 72 hours after receipt of the appeal. For urgent care benefit claims, there is only one level of appeal.

Special Note for Urgent Care Appeals for HMO Illinois Participants

Upon receipt of an urgent/expedited pre-service or concurrent clinical appeal, HMO Illinois will notify the party filing the appeal, MG/IPA or PCP as soon as possible, but no more than 24 hours after submission

of the appeal, of all the information needed to review the appeal. Any required additional information must be submitted within 24 hours of the request. HMO Illinois shall render a determination on the appeal within 24 hours after it receives the requested information.

Second Level Appeals

If you are not satisfied with the determination of the claims administrator on your first level appeal, you can submit a second level appeal (except with respect to urgent care claims). All second level appeals should be submitted in writing to the claims administrator within 180 days (within 60 days in the case of a Vision Plan claim) after you receive the notice of determination on your first level appeal.

Like first level appeals, the review of a second level appeal will afford no deference to prior determinations and will be conducted by someone other than individuals involved in prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the claims administrator will consult a health professional other than the professional consulted for the first level appeal. The claims administrator will provide you written or electronic (via-email) notification of the determination as follows:

- For appeals of pre-service claims, no later than 15 days after receipt of your request for a second level appeal.
- For appeals of post-service claims, no later than 30 days after receipt of your request for a second level appeal.

Explanation of Denied Health Plan Appeals

If your appeal regarding benefits under the Health Plans is denied, the written explanation of the denial will:

- state why the claim has been denied, citing applicable Health Plans provisions;
- state that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim (if you are a participant in the HMO Illinois option, you may be subject to charges if you request documents or records directly from your medical group, instead of going through the claims and appeals process);
- explain the voluntary appeal procedures offered;
- explain your right to bring a civil action against the Health Plans under ERISA Section 502(a) within one year of receipt of the denial;
- disclose any internal rule, guideline, protocol, or similar criterion relied on in denying the claim (or a statement that such information will be provided free of charge upon request); and
- if the denial is based on a medical necessity, experimental treatment or similar exclusion, explain the scientific or clinical judgment relied on for the determination (or a statement that such explanation will be provided free of charge upon request).

Additional Details Regarding Medical Plan Appeal Denials

If your appeal regarding Medical Plan benefits is denied, the written explanation of the denial will, in addition to the information listed above:

- include information that allows you to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable));
- include a statement describing the availability of the relevant diagnosis and treatment codes and their corresponding meanings (if you request this information, it will be provided to you as soon as practicable following your request);
- provide the code assigned to the reason for the denial, the meaning of the code, a description of the standard that was used in denying the claim (if any), and, for final appeal decisions, a discussion of the decision to deny the appeal;
- describe the internal appeals procedures and external review processes for Medical Plan benefits, including information about how to initiate both an internal appeal and an external appeal; and
- include contact information for any applicable office of health insurance consumer assistance or ombudsman that is available to help you with the appeals process.

If new or additional evidence is considered, relied upon or generated by the Medical Plan as part of the appeal review, or if an appeal denial is based on a new or additional rationale than was considered in your initial claim for benefits, you will be provided with this evidence and/or rationale as soon as possible and sufficiently in advance of the date on which any notice of an appeal denial is required, so that you may have a reasonable chance to respond.

Coverage under the Medical Plan will continue pending the outcome of the appeal, so that benefits for an ongoing course of treatment are not reduced or terminated without providing you advance notice and an opportunity for advance review of the appeal.

External Review of Denied Medical Plan Claims and Appeals

If your Medical Plan claim or appeal is denied, you may request to have an Independent Review Organization ("IRO") conduct a standard external review or expedited external review of the denial, as described below. External review may be available if your claim or appeal involves a rescission of Medical Plan coverage, or involves medical judgment (*e.g.*, if the determination is based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or includes a determination that a particular treatment is experimental or investigational).

Standard External Review

Request for External Review

You may file a request for standard external review within four (4) months after you receive notice from the claims administrator that your Medical Plan claim or appeal has been denied. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date you receive the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary Review

Within five (5) business days following the date of receipt of your external review request, the claims administrator will complete a preliminary review of the request to determine whether:

- You are, or were, covered under the Medical Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Medical Plan at the time the health care item or service was provided;
- The claim denial or the appeal denial involves either medical judgment or a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time);
- You have exhausted the Medical Plan's internal appeals process, unless you are not required to exhaust the internal appeals process under the law. Please refer to the ***Exhaustion*** section below for additional information about exhaustion of the internal appeal process; and
- You have provided all the information and forms required to process an external review.

You will be notified within one (1) business day after the claims administrator completes the preliminary review if your request is eligible for external review, or if further information or documents are needed. You will have the remainder of the four-month period described above (or 48 hours following receipt of the notice, if later) to perfect your request for external review.

If your claim is not eligible for external review, the claims administrator will outline the reasons it is ineligible in the notice and will provide contact information for the Department of Labor's Employee Benefits Security Administration.

Referral to Independent Review Organization

If you submit your request for external review within the four-month time period described above and your claim is eligible for external review, the claims administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by a similar nationally-recognized accrediting organization, and

the IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits. In addition, the claims administrator has taken administrative steps to ensure independence in the external review process, such as using unbiased methods for selecting IROs to review claims.

When your request for external review is eligible and assigned to an IRO, the following procedures will apply:

- The IRO will utilize legal experts where appropriate to make coverage determinations under the Medical Plan.
- The IRO will timely notify you, in writing, that your request for external review is eligible and has been accepted for external review. This notice will include a statement that you may submit in writing to the assigned IRO additional information within 10 business days following the date of receipt of the notice, and that the IRO will be required to consider this additional information when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.
- Within five (5) business days after the date of assignment of the IRO, the claims administrator will provide to the assigned IRO the documents and any information considered in making the claim denial or appeal denial.
- Failure by the claims administrator to timely provide the documents and information will not delay the IRO from conducting the external review. If the claims administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the claim denial or appeal denial. Within one (1) business day after making such a decision, the IRO will notify you and the claims administrator.
- Within one (1) business day of receiving any information submitted by you, the assigned IRO will forward the information to the claims administrator. Upon receipt of any such information, the claims administrator may reconsider its claim denial or appeal denial that is the subject of the external review.

  Reconsideration by the claims administrator will not delay the external review. The external review may be terminated as a result of the reconsideration only if the claims administrator decides, upon completion of its reconsideration, to reverse its claim denial or appeal denial and provide coverage or payment. Within one (1) business day after making such a decision, the claims administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate its external review upon receipt of the notice from the claims administrator that the claims administrator has decided to reverse its claim denial or appeal denial.
- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - Your medical records.
  - The attending health care professional's recommendation.
  - Reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your treating provider.
  - The terms of the Medical Plan to ensure that the IRO's decision is not contrary to the terms of the Medical Plan, unless the terms are inconsistent with applicable law.
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations.
  - Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Medical Plan or with applicable law.

- The opinion of the IRO's clinical reviewer or reviewers after considering the information described above, to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- The IRO will provide you and the claims administrator with written notice of the final external review decision within 45 days after the IRO receives the request for the external review.

  The notice of final external review decision will include the following information:

  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial).
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision.
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence—based standards that were relied on in making its decision.
  - A statement that the determination is binding, except to the extent that other remedies may be available under State or Federal law to either you or the claims administrator.
  - A statement that judicial review may be available to you.
  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman that may be available to assist you.

- After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO will make such records available for examination by you, the claims administrator, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Decision
Upon receipt of a notice of a final external review decision reversing the claim denial or appeal denial, the claims administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

Request for Expedited External Review
You may make a request for an expedited external review with the claims administrator at the time you receive either of the following:

- An claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, provided that you have already filed a request for an expedited internal appeal.

- An appeal denial that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the appeal denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

Preliminary Review
Immediately upon receipt of the request for expedited external review, the claims administrator will complete a preliminary review to determine whether the request meets the reviewability requirements set forth in the ***Standard External Review*** section above. The claims administrator will immediately send you

a notice of its eligibility determination that meets the requirements set forth in the "Standard External Review" section above.

Referral to Independent Review Organization
Upon a determination that a request is eligible for external review following the preliminary review, the claims administrator will assign an IRO pursuant to the requirements set forth in the ***Standard External Review*** section above.

The claims administrator will provide or transmit all necessary documents and information considered in making the claim denial or appeal denial to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures set forth in the "Standard External Review" section. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process.

Notice of Final External Review Decision
The IRO will provide notice of the final external review decision, in accordance with the content requirements set forth in the "Standard External Review" section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to you and the claims administrator.

Exhaustion
For standard internal appeals, you have the right to request external review after you have completed the required internal appeals process and you have received a final appeal denial. For expedited internal appeals, you may request external review simultaneously with your request for an expedited internal appeal. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal appeals process must be completed before external review may be requested.

External review may not be requested for a claim denial involving a post-service claim until the internal appeals process has been exhausted. You will be deemed to have exhausted the internal appeals process and may request external review if the claims administrator waives the internal appeals process or the claims administrator has failed to comply with the internal claims and appeals process.

Before you may bring any legal action to recover benefits, you must exhaust the required internal claim and appeal process, and your appeal must be decided by the claims administrator. In the event you have been deemed to exhaust the internal appeals process due to the failure by the claims administrator to comply with the internal claims and appeals process, you will have the right to pursue any available remedies under 502(a) of ERISA or under State law.

Action	Post-Service Care Claim	Pre-Service Care Claim (non-urgent)	Urgent Care Claim
Initial decision on complete claim	30 days[1]	15 days[1]	as soon as possible, and within 72 hours[2]
How long you have to submit your appeal of a denied claim	180 days	180 days	180 days
Decision on appeal: • First level appeal	30 days	15 days	72 hours

• Second level appeals	30 days	15 days	n/a
How long you have to submit a request for external review	4 months[3]	4 months[3]	4 months[3]
IRO decision on external review	45 days	45 days	72 hours

1. Extension may be necessary if proper notice has been given and the delay is beyond the program administrator's control.
2. 24 hours for HMO Illinois
3. In the event that there is no applicable date that falls exactly 4 months after the date on which you receive notice that your internal appeal has been denied, then you must submit your request for external review by the first day of the fifth month following the date you receive the internal appeal denial notice. For example, if you receive a denial notice on October 30, you may request an external review no later than the following March 1 (i.e., because there is no February 30).

Submitting Health Care Appeals

For both first and second level appeals, you should submit your appeal to the applicable claims administrator at the address indicated below.

Claims Administrator	Phone Number	Address
Blue Cross Blue Shield PPO **BlueEdge CDHP**	800-458-6024	Claim Review Section Blue Cross and Blue Shield of Illinois P.O. Box 2401 Chicago, IL 60690-1364
HMO Illinois	800-892-2803	Claim Review Section Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago IL 60680-4112
Blue Cross Blue Shield PPO Dental Plan	800-367-6401	Blue Cross Blue Shield of Illinois P.O. Box 23059 Belleville, IL 62223-0059
Vision Service Plan	800-877-7195	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670

Exhaustion of Administrative Remedies

These claims and appeals processes are provided in the hope that most disputes can be resolved. You or your covered dependents must follow and exhaust all the internal administrative remedies described above prior to bringing an action for benefits under the Health Plans under Section 502(a) of ERISA.

Limitations on Actions

No legal action may be brought to recover under the Medical Plan or the Dental Plan after the expiration of one year following the date on which you received the final notice of denial of your health care appeal. If you do not bring an action within such one-year period, you will be barred from bringing an action under ERISA related to your claim.

Special Note for Limitations on Actions for Vision Service Plan Participants

No legal action may be brought to recover under the Vision Plan, prior to the expiration of sixty (60) days after your claim and any applicable invoices have been submitted to VSP in connection with benefits under the Vision Plan. In addition, no such legal action may be brought after the expiration of three (3) years from the last date that your claim and any applicable invoices were submitted to VSP.

PRIVACY OF HEALTH INFORMATION

Under federal law, special rules apply to the privacy of your health information. For more information about the confidentiality of your protected health information ("PHI") and how it may be used and disclosed, please refer to the Health Plans' Notice of Privacy Practices (the "Notice"). The Notice explains how you may access and amend your PHI, request an accounting of disclosures of your PHI, and request restrictions on disclosures of you PHI. You may request a copy of the Notice by contacting the Plan Administrator. Other policies adopted by the Health Plans contain standards designed to maintain the security of your PHI.

HOW THE HEALTH PLANS WORK WITH OTHER PLANS

If you, your spouse or your dependents are covered by the Health Plans and another medical plan, Health Plans benefits will be coordinated with benefits from the other plan. This coordination eliminates duplicate payments and lowers health care costs.

Under this coordination of benefits ("COB") provision, one plan is considered primary and the other plan is considered secondary. This provision does not apply to outpatient prescription drug products dispensed at participating pharmacies or to mail service prescription drugs.

General Rules to Determine Payment Responsibility

If the Health Plans are primary, DePaul pays benefits without regard to any other plans. If the Health Plans are secondary, DePaul pays the difference (if any) between the amount that would have been paid if the Health Plans were primary, and the amount that the primary plan actually paid (or would have paid if primary coverage is assumed). You can determine whether the Health Plans or another plan is primary by using the rules described below. The rules apply in the order that follows, so the first rule that applies to your situation will determine whether the Health Plans pay primary.

- If one plan does not have a COB provision, it will automatically pay primary.
- When both plans have a COB provision, the plan that covers the individual other than as a dependent (*e.g.,* employee, member, retiree) will pay primary, and the plan that covers the individual as a dependent will pay secondary.
- Children covered by more than one plan (when the parents are not legally separated or divorced) are covered first by the plan of the parent whose birthday falls earlier in the year and second by the other parent's plan. In determining the birthday, only the month and day are considered. Should both parents have the same birthday, then the plan of the parent who has been covered longer pays primary and the other plan pays secondary.
- Children covered by more than one plan when the parents are separated (whether or not ever married) or divorced will be covered:
  - first by the plan of the parent having custody of the child,
  - second by the plan of the spouse of the parent having custody of the child,
  - third by the plan of the parent not having custody of the child, and
  - finally by the plan of the spouse of the noncustodial parent.

  However, if there is a court decree specifying the responsibility for coverage on the child, then the plan of the parent having that responsibility will pay primary.
- A plan that covers the individual as an active employee who is neither laid off nor retired (or, in the case of a dependent, a plan that covers the individual as a dependent of an active employee) is primary to a plan that covers the individual as an inactive employee (or, in the case of a dependent, a plan that covers the individual as a dependent of a former employee).

- If the other plan does not have this rule, and the plans do not agree on the order of benefits, then this rule does not apply.

- If an individual is covered under COBRA coverage or state continuation coverage, the plan covering the individual as an employee, member or retiree (or as that person's dependent) pays first, and the continuation coverage pays second.
  - This rule applies only when both plans provide non-dependent coverage to the individual or both plans provide dependent coverage to the individual.
  - If one plan provides dependent coverage and the other plan provides non-dependent coverage, the second rule in this section applies (*i.e.*, the plan that covers the individual as a dependent will pay secondary).
  - If the other plan does not have this rule, and the plans do not agree on the order of benefits, then this rule does not apply.
- If none of the above rules will serve to determine the order of payment of a claim, the plan that has covered the individual the longest will pay first.

Coordination of Benefits with Medicare

If you or your dependent is eligible for Medicare, the coordination of your benefits works differently from the above rules. In the case of Medicare, each individual who is eligible for Medicare will be assumed to have full Medicare coverage (Part A and Part B), whether or not the individual actually enrolls for full coverage. Generally, the following rules apply if you or your dependent is eligible for Medicare:

- If you have active employee coverage under the Health Plans and you or your spouse is eligible for Medicare on the basis of age, the Health Plans will be primary (so DePaul will pay benefits for the Medicare eligible person before Medicare pays). If you have active employee coverage under the Health Plans and your SDA is eligible for Medicare on the basis of age, Medicare will be primary (so it will pay benefits for the Medicare eligible person before DePaul pays).
- If you have active employee coverage under the Health Plans and you or your dependent is eligible for Medicare on the basis of disability, the Health Plans will be primary (so DePaul will pay benefits for the Medicare eligible person before Medicare pays).
- If you have coverage under the Health Plans for a reason other than active employment (*e.g.*, COBRA coverage, retiree coverage, or coverage after the sixth month that you receive disability benefits) and you or your dependent is eligible for Medicare, Medicare will be primary (so it will pay benefits for the Medicare eligible person before DePaul pays).
- If you or your dependent has end-stage renal disease (ESRD) (i.e., on kidney dialysis or needing a kidney transplant), the Health Plans will be primary for the first 30 months of ESRD treatment (i.e., the 30-month period beginning with the month in which eligibility for Medicare benefits for ESRD begins). After the first 30 months, Medicare will pay primary.

In order to assist DePaul in complying with Medicare Secondary Payer laws, it is very important that you promptly and accurately complete any requests for information from the claims administrator or DePaul regarding your Medicare eligibility, or the Medicare eligibility of your spouse or your covered dependent children. In addition, if you, your spouse or your covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact DePaul promptly to ensure that your claims are processed in accordance with applicable coordination of benefits rules.

If you have any questions about which rules fit your situation, contact the Benefits Department.

THIRD PARTY LIABILITY

This provision modifies any coverage under the Health Plans.

Right to Reimbursement

Sometimes, you or a covered family member may have a claim for a sickness or injury, such as from a car accident, that someone else is legally responsible to pay. The portion of the expense that the other party (which may be an individual, a company or an insurer) is responsible for paying is not considered an eligible expense under the Medical Plan.

However, the Health Plans will pay benefits for a claim that someone else is responsible for paying if:

- the other person has not paid; and
- you (or your legal representative) agree in writing to reimburse the money promptly when the other person pays or another party (such as an insurance company) pays for him or her.

You must reimburse the Health Plans from any recovery to the extent of benefits the Health Plans paid on your behalf, regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries or fully satisfy the judgment, settlement or underlying claim for damages. Notwithstanding any allocation or designation of your recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Health Plans shall have a right of full recovery, in first priority, against any recovery. This right of reimbursement will apply whether or not the party who is responsible for the payment admits liability, whether or not the payments are itemized or allocated to medical expenses, and whether or not the covered individual has been made whole.

If you make such an agreement and receive payment from the Health Plans, it is possible that you will incur costs, including attorney's fees, in trying to obtain payments from the responsible party. If you do incur such costs, you may then deduct a reasonable share of costs that you incur in obtaining payment from the responsible party from the amount that you owe the Health Plans, as determined by the Plan Administrator in the exercise of its sole discretion.

Any settlement proceeds, assets collected from judgments and recoveries paid by a third party shall be held for the Health Plans, and the Health Plans' interest therein shall be protected to the same extent as if such proceeds or assets were held in trust for the benefit of the Health Plans, to the extent of the amount paid by the Health Plans and subject to reimbursement to the Health Plans. By accepting benefits under the Health Plans, you agree that any amounts you recover from a third party are assets of the Health Plans (up to the amount of benefits provided by the Health Plans on your behalf), that you will be a fiduciary of the Health Plans with respect to those amounts, and that you will be responsible for repaying to the Health Plans any costs and fees (including reasonable attorney fees) that the Health Plans incurs to enforce its rights with respect to reimbursement of those amounts. You also agree that, to the extent you have control over such assets, you will exercise all authorities consistent with the Health Plans' interest in such assets.

If you do not repay the Health Plans all or a part of an amount that you have agreed to pay, that amount may be deducted from other benefits payable to you under the Health Plans after payments by or for the responsible person are made.

Reimbursement Provision for HMO Illinois Participants Only

If you or your covered dependents incur expenses for sickness or injury that occurred due to the negligence of a third party, and benefits have been provided for covered services described in the certificate booklet, you agree to the following:

- The Medical Plan has the right to reimbursement for all benefits the Medical Plan provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise, by the covered person or the covered person's legal representative as a result of that sickness or injury:
  - In the case of health care facilities and certain contracted providers, the calculation of any lien shall be based on the amount the Medical Plan charges the policyholder's experience for covered services rendered to the covered person; and

- In the case of providers other than health care facilities, the calculation of any lien shall be based on the Medical Plan's benefit payment for covered services rendered to the covered person.

- The Medical Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Medical Plan provided for that sickness or injury. The Medical Plan shall have the right to first reimbursement out of all funds the covered person or the covered person's legal representative, is or was able to obtain for the same expenses for which the Medical Plan has provided benefits as a result of that sickness or injury.

For the purposes of this provision, the cost of benefits provided will be the charges that would have been billed if the covered person had not been enrolled under this benefit program. The covered person is required to furnish any information or assistance or provide any documents that the Medical Plan may reasonably require in order to obtain its rights under this provision.

Subrogation of Health Plans

In addition to the Health Plans' right to reimbursement, if the Health Plans pay benefits to you or a covered family member for a sickness or injury that another party is responsible for paying, the Health Plans will be subrogated to the amount of benefits it paid. This means that the Health Plans take on the rights you or a covered family member have to bring a lawsuit or make a claim against any person or insurer whose act or failure to act caused the sickness and injury from whom you could recover payment for the sickness or injury. You have the following obligations:

- To notify the Plan Administrator of any responsible person or insurer that you may have a claim against, including an insurance company;
- To notify the Plan Administrator of any claims for damages made in connection with the sickness or injury; and
- To fully cooperate with the Plan Administrator and the claims administrator in obtaining information, providing relevant documents, and signing any necessary forms. You will be required to sign a document that assigns to the Health Plans your right of payment from an insurer or other responsible party, but only up to the amount that the Health Plans paid for the claim. If a covered family member is a minor, the Health Plans may require that a court appoint a legal representative to act on behalf of the minor.

The Health Plans will place a lien against any responsible person, that person's insurer, and your insurer; and suspend payment of future benefits pending receipt of documents and forms it needs to act under this subrogation provision. If the Health Plans, DePaul, or you bring an action against the responsible person or insurer, the party bringing the action must provide written notice of it to the other parties by personal service or registered or certified mail. The Plan Administrator in its discretion will determine whether to exercise the Health Plans' subrogation rights.

ADMINISTRATIVE INFORMATION ABOUT THE HEALTH PLANS

Plan Administrator

DePaul, as the Plan Administrator has the sole and complete discretionary authority to determine eligibility for Health Plans benefits and to construe the terms of the Health Plans and the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Health Plans. Benefits under the Health Plans will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions relating to the Health Plans.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Health Plans and the Plan, and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Health Plans and the Plan. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for the administration of the plan from time to time, as it deems necessary or appropriate.

Facility of Payment

If you or a covered dependent are under a legal disability, or in the opinion of the Plan Administrator are in any way incapacitated so as to be unable to manage your financial affairs, the Plan Administrator may direct the claims administrator to make payments or distributions to:

- the covered person's legal representative; or
- until a claim is made by a conservator or other person legally charged with the care of the person, to a relative or friend of such person for such person's benefit.

Or, the Plan Administrator may direct payments or distributions for the benefit of the covered person in any manner that is consistent with the provisions of the Health Plans. Any payments so made will be a full and complete discharge of any liability for such payment under the Health Plans.

Benefits Not Transferable

Except as otherwise permitted by the Plan Administrator to assign benefits to providers, or as may be required by a qualified medical child support order, or applicable tax withholding laws, or pursuant to an agreement between you and DePaul, your benefits under the Health Plans are not in any way subject to you or your dependents' debts and may not be voluntarily sold, transferred, alienated or assigned.

Recovery of Benefits

If you or a covered dependent receive a benefit payment under the Health Plans that is in excess of the benefit payment that should have been made, the Plan Administrator has the right to recover the amount of the excess. The Plan Administrator may, however, at its option, direct the claims administrator or trustee to deduct the amount of the excess from any subsequent benefits payable under the Health Plans to or for the benefit of you or the covered dependent.

Information to be Furnished

You must furnish DePaul, the Plan Administrator, the insurance companies and the claims administrators with the information they consider necessary or desirable to administer the Health Plans. If you make a fraudulent misstatement or omission of fact in an enrollment form or a claim for benefits under the Health Plans, it may be used to deny claims for benefits under the Health Plans.

Physical Exam

The Plan Administrator, at its own expense, has the right and opportunity to have the person whose injury or sickness is the basis of a claim, examined by a physician designated by it, when and as often as it may reasonably require while a claim is pending under the Health Plans.

Governing Law

The Health Plans shall be governed by the laws of Illinois, to the extent not superseded by federal law. If any part of any program is determined to be invalid or illegal for any reason, the remaining provisions of the Health Plans shall be applied as if the illegal or invalid provision had never been a part of the Health Plans.

STATEMENT OF YOUR RIGHTS UNDER FEDERAL LAW (ERISA)

As a participant in the Health Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Health Plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Health Plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Health Plans, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Health Plans' annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. (Not applicable to certain programs.)

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Health Plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Health Plans on the rules governing your COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Health Plans participants, ERISA imposes duties upon people who are responsible for the operation of the Health Plans. The people who operate the Health Plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within a certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request copies of Health Plans documents or the latest annual report from the Health Plans and do not receive them within 30 days, you may file suite in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Health Plans' decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Health Plans fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Health Plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the

Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

Plan Name	This SPD describes benefits under the DePaul University Medical Plan, the DePaul University Dental Plan, the DePaul University Vision Plan, and the Pre-Tax Premium Option, which are offered under the DePaul University Health and Welfare Benefits Plan.
Employer Identification Number	36-2167048
Plan Number	The Health Plans are part of the DePaul University Health and Welfare Benefits Plan, and the plan number is 520.
Type of Plan	Group health plan and cafeteria plan under IRC Section 125
Plan Year End Date	December 31st
Address for Plan Sponsor	DePaul University Office of Human Resources 1 East Jackson Boulevard Chicago, IL 60604-2287
Plan Funding	The HMO Illinois option under the Medical Plan and the Vision Plan are fully insured benefit options. All other benefits available under the Health Plans are self-funded benefit options.
Type of Administration	Contract administration (except HMO Illinois and Vision Service Plan are insurer administration)
Claims Administrators	
CDHP Option, PPO Option	Blue Cross Blue Shield Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680-4112 800-458-6024
HMO Illinois Option	HMO Illinois Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680-4112 800-892-2803
Dental Plan	Blue Cross Blue Shield PPO Dental Plan Blue Cross Blue Shield of Illinois P.O. Box 23059 Belleville, IL 62223-0059 800-367-6401
Vision Plan	Vision Service Plan VSP – Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195
COBRA Administrator	Conexis Benefits Administrator, LP CONEXIS P.O. Box 226101 Dallas, TX 75222

	phone: 877-722-2667
Address for Plan Administrator	DePaul University (or its delegate) Office of Human Resources 1 East Jackson Boulevard Chicago, IL 60604-2287 312-362-8232
Address for Service of Legal Process	Jose Padilla Vice President and General Counsel De Paul University 55 East Jackson Boulevard, 22nd Floor Chicago, IL 60604-2287 Legal process may also be made upon the Plan Administrator c/o Office of the General Counsel DePaul University 55 East Jackson Boulevard, 22nd Floor Chicago, IL 60604-2287

The sections of this document, called the Summary Plan Description (SPD), summarize the DePaul Health Plans in easy-to-understand language. The complete provisions of the Health Plans are found in the official Plan documents, which govern in the case of any difference between them and this document. If you would like to review the official Plan documents, or to obtain a copy of any Plan document, please contact the Benefits Department.

This summary describes the Health Plans in effect as of January 1, 2018.

Participation in the Health Plans in no way guarantees employment with DePaul. While DePaul expects to continue the Health Plans indefinitely, it reserves the right to terminate, suspend, withdraw, amend or modify all or any part of the Health Plans or the Plan, at any time, by written action of DePaul or its duly authorized delegate. Any such change or termination of the Health Plans or the Plan will be based solely on any decision of the Plan Sponsor and may apply to any or all groups of employees – including active and disabled employees, and current or future retirees and their dependents – as determined under the Health Plans. Any material change will be explained to you within a reasonable period of time of when it is adopted, in accordance with any legal requirements regarding notification of material changes.

No supervisor, manager or other representative of DePaul has any authority to enter into any oral or written agreement contrary to the foregoing or contrary to the terms of any Summary Plan Description or applicable plan document.