



Medical Plan for Retirees Age 65 and Over

Summary Plan Description

(Effective: October 1, 2017)

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GENERAL INFORMATION

This summary plan description (“SPD”) contains general information about the DePaul University Medical Plan for Retirees Age 65 and Over (the “Over-65 Retiree Plan”), which is offered under the DePaul University Health and Welfare Benefits Plan (the “Plan”), sponsored by DePaul University (“DePaul”). This SPD includes information relating to:

- Who is eligible to participate in the Over-65 Retiree Plan
- How to enroll in the Over-65 Retiree Plan
- When you may change your coverage under the Over-65 Retiree Plan
- When your coverage under the Over-65 Retiree Plan ends
- Benefits available under the Over-65 Retiree Plan
- How to file your claims for benefits
- How to appeal if your claim is denied
- Your privacy rights with respect to the Over-65 Retiree Plan
- Your rights under federal law (including ERISA)
- Administrative information about the Over-65 Retiree Plan

For the Over-65 Retiree Plan, a “plan year” is January 1 to December 31. This SPD describes the Over-65 Retiree Plan in effect as of October 1, 2017.

WHO IS ELIGIBLE

You are eligible for coverage under the Over-65 Retiree Plan if you are in one of the categories described below.

Individuals Who Retired Before Age 65

If you retired before reaching age 65, upon reaching age 65 as a Retiree, you will be eligible to enroll in the Over-65 Retiree Plan if you meet the following conditions:

- You previously enrolled in medical coverage under the DePaul University Medical Plan (the “Medical Plan”) as a pre-65 Retiree (see the separate SPD for the DePaul University Health Benefits Plans (“Health Plans”) for pre-65 Retiree eligibility requirements); and
- You continue to be covered under the Medical Plan as a pre-65 Retiree through the last day of the month prior to your 65th birthday.

DePaul will notify you of your eligibility for the Over-65 Retiree Plan prior to the first day of the month in which you turn age 65 and will explain the steps you need to take to complete enrollment in the Over-65 Retiree Plan.

Individuals Who Retire On or After Age 65

If you retire on or after you reach age 65, you will be eligible to enroll in the Over-65 Retiree Plan if you meet the following conditions as of the date of your retirement:

- You are enrolled in 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 the Over-65 Retiree Plan); or
 - member of DePaul’s sponsoring religious order; and
- You have at least 10 years of cumulative full-time service with DePaul.

Excluded Classifications

You are not eligible to enroll in the Over-65 Retiree Plan if, prior to your retirement, you are:

- covered by a collective bargaining agreement;
- in a position classified as a student employee;
- in an instructional associate position;
- in a position classified as a temporary employee;

- a part-time employee;
- 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;
- designated by DePaul to be an independent contractor (whether determined at a later date to be a common law employee or otherwise); or
- a Trustee.

How Your Contribution Towards Coverage Is Determined

If you were hired on or before April 1, 2006 into a full-time faculty or staff position, or if you have an official offer of employment letter for a full-time faculty or staff position dated on or before April 1, 2006, you and DePaul will share in the cost of your coverage under the Over-65 Retiree Plan. If you elect medical coverage for your spouse or unrelated Second Domiciled Adult (“Unrelated SDA”) as described below in **Eligible Dependents**, DePaul will also share in the cost of coverage for your spouse or Unrelated SDA. The amount you pay for coverage will depend on your Grandfathered Group classification, as outlined in the chart below.

If you were hired after April 1, 2006 and you do not have an official offer of employment letter for a full-time faculty or staff position dated on or before April 1, 2006, you will pay the full amount of the cost for your coverage under the Over-65 Retiree Plan, as well as the full amount of the cost for medical coverage for any dependents you choose to cover.

As a Retiree, you pay for all coverage you elect on an after-tax basis. Premium payments and any other required payments must be sent to Blue Cross Blue Shield (for the Medicare Advantage option) or to DePaul (for the Medicare HMO option) at the applicable address included at the end of this SPD under **General Plan Information**.

Grandfathered Group	Definition	How Your Contribution Is Calculated
Category One*	Includes all eligible Retirees who retired before July 1, 2004.	You pay 20% of the cost of coverage.* DePaul pays 80% of the cost of coverage for you, your spouse or Unrelated SDA and/or your dependent children.
Category Two	Includes all eligible Retirees who: <ul style="list-style-type: none"> ▪ were actively employed by DePaul as of July 1, 2004; and ▪ satisfied one of the following combinations of age and service, as of July 1, 2004: <ul style="list-style-type: none"> ➤ at least age 55, with 20 years of cumulative full-time service, or ➤ at least age 62, with 10 years of cumulative full-time service. 	You pay 20% of the cost of coverage. DePaul pays 80% of the cost of coverage for you, your spouse or Unrelated SDA and/or your dependent children.
Category Three	Includes all eligible Retirees who: <ul style="list-style-type: none"> ▪ were hired by DePaul before January 1, 1994 and were actively employed by DePaul as of July 1, 2004; and ▪ satisfied one of the following combinations of age and service, as of July 1, 2009 (but not as of July 1, 2004): 	You pay 30% of the cost of coverage. DePaul pays 70% of the cost of coverage, for you, your spouse or Unrelated SDA and/or your dependent children.

Grandfathered Group	Definition	How Your Contribution Is Calculated
	<ul style="list-style-type: none"> ➤ at least age 55, with 20 years of cumulative full-time service, or ➤ at least age 62, with 10 years of cumulative full-time service. 	
Category Four	<p>Includes all eligible Retirees who were actively employed by DePaul as of July 1, 2004 and who, as of July 1, 2004:</p> <ul style="list-style-type: none"> ▪ had at least 20 years of service; but ▪ had not yet reached age 55. 	<p>You pay 30% of the cost of coverage. DePaul pays 70% of the cost of coverage for you, your spouse or Unrelated SDA and/or your dependent children.</p>
Category Five	<p>Includes all eligible Retirees who:</p> <ul style="list-style-type: none"> ▪ were hired by DePaul on or before April 1, 2006; OR ▪ have an official offer of employment letter for a full-time faculty or staff position, that is dated on or before April 1, 2006; <u>and</u> ▪ do not meet the requirements for Grandfathered Group Categories 1 – 4. <p>Includes all eligible Retirees who:</p> <ul style="list-style-type: none"> ▪ have an <u>original</u> full-time hire date that is before April 2, 2006; and ▪ retired and were re-hired by DePaul into a <u>full-time</u> faculty or staff position after April 1, 2006. 	<p>DePaul pays a flat-dollar amount towards the cost of coverage.</p> <p>This flat-dollar amount is calculated as follows:</p> <ul style="list-style-type: none"> ▪ 80% of the full premium amount that was in effect as of July 1, 2004, increased each year by the greater of: <ul style="list-style-type: none"> ➤ the Consumer Price Index, or ➤ the weighted DePaul University tuition increase. <p>Beginning in 2013, if the percentage increase in the full premium amount for the year is less than the increase in the Consumer Price Index or the weighted DePaul University tuition increase, then the percentage change in the full premium amount (whether positive or negative) will be applied equally to the premium paid by DePaul and the premium you pay.</p> <p>You pay the difference between the cost of coverage (including coverage for your spouse or Unrelated SDA and/or your dependent children), and the flat-dollar amount that DePaul pays.</p>

*If you are in Grandfathered Group – Category One and you retired prior to November 26, 1990 under an agreement that states that you pay a fixed cost for Over-65 Retiree Plan coverage, the amount you pay for your coverage is stated in the terms of the applicable agreement.

If you, your spouse or Unrelated SDA, or both of you, are covered under the Over-65 Retiree Plan and other dependents are covered under the pre-65 retiree coverage under the Medical Plan, the Plan Administrator determines your premiums by blending the applicable rate for coverage under the Over-65 Retiree Plan with the applicable rate for coverage under the Medical Plan, to determine the overall cost for coverage elected under both plans.

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 may end.

If you have already begun receiving benefits under the Over-65 Retiree Plan 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 the Health Plans SPD), you will no longer be eligible to participate in the Over-65 Retiree Plan, 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 your Grandfathered Group classification will be determined using your initial date of hire 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 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 to reenroll at that time in retiree coverage under the Over-65 Retiree Plan, 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 Over-65 Retiree Plan at a later date, under any circumstances.

ELIGIBLE DEPENDENTS

If you are eligible to enroll in coverage under the Over-65 Retiree Plan, you also may enroll (or continue coverage for) your spouse or Unrelated SDA who is age 65 or older and eligible for Medicare in the Over-65 Retiree Plan.

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

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

- 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.

For coverage terms applicable to your spouse or SDA who has not yet reached age 65 and become eligible for Medicare, your dependent children, or your SDA's children, under the PPO option or the HMO Illinois option offered under the Medical Plan, see the separate Health Plans SPD. Note that your Related SDA is not eligible for coverage under the Over-65 Retiree Plan.

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, DePaul is required to report as taxable income to you the value of the health coverage DePaul provides on behalf of the Unrelated

SDA. 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:

- 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 an Unrelated SDA will automatically be on a taxable basis, unless you return a completed *Declaration of Tax Status* form to the Benefits Department; 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; and
- Report this amount (less your after-tax contributions) as income to you on a W-2.

Requirement to Notify DePaul if Your Dependent's Eligibility Changes

If your dependent ceases to satisfy the eligibility requirements for coverage, you must notify DePaul within 31 days following the event.

Important Note Regarding Ineligible Dependents

If you cover a dependent who, in fact, does not meet the eligibility requirements, you will be responsible for reimbursing claims paid on behalf of the dependent, for any time during which the dependent was not an eligible dependent. Further, you may be subject to back taxes and IRS penalties.

PROGRAM OVERVIEW

DePaul offers two options for medical coverage for over-65 Retirees, the Medicare Advantage option and the Medicare HMO option. Each of these options is available to all Retirees who enroll in the Over-65 Retiree Plan. Each option provides a comprehensive prescription drug benefit, in addition to medical benefits.

The Medicare Advantage option requires you to enroll in Medicare Part A and Part B before you can elect coverage under this option. If you do not enroll in Medicare Part A and Part B, you will not be permitted to elect the Medicare Advantage option.

The Medicare HMO option is intended to coordinate with your coverage under Medicare, so this option pays benefits under the assumption that you have enrolled in Medicare Part A and Part B. If you do not enroll in Medicare Part A and Part B, the Over-65 Retiree Plan will not pay expenses that would have been covered by Part A and Part B.

Specific details about each program option can be found in ***Program Details***.

MEDICARE OVERVIEW

Medicare is health insurance for people age 65 and older, or those under age 65 with certain disabilities. This section provides a brief overview of Medicare. It is provided for informational purposes only. It is not intended to serve as an official Medicare plan summary. If there is any conflict between the information in this document and Medicare law, Medicare law will always govern. Call 800-MEDICARE or visit www.medicare.gov for more information.

When Medicare Coverage Begins

You are eligible to enroll in Medicare upon the earliest of the following:

- The first of the month in which you turn age 65;
- If you are receiving Social Security Disability benefits, the first of the month after you have received such benefits for 24 months; or
- If you are entitled to End-Stage Renal Disease benefits, three months after your dialysis starts, or the month you enter a Hospital for a transplant.

Medicare Part A

Eligibility and Enrollment

Medicare Part A is also known as basic Medicare, or the hospital insurance benefit. If you are receiving Social Security or Railroad Retirement benefits, you are eligible for Medicare Part A and will be enrolled automatically.

If you meet any of the following criteria, you must apply for Medicare Part A:

- You have End-Stage Renal Disease;
- You are entitled to disabled widow's or widower's benefits;
- You are at least age 65, and you did not apply for Social Security retirement benefits.

Covered Expenses

Medicare Part A covers the following types of expenses:

- In-patient hospital care;
- In-patient care in a skilled nursing facility;
- Hospice care services; and
- Home health care services.

Expenses That Are Not Covered

Medicare Part A does not cover the following types of expenses:

- Services covered by Medicare Part B;
- Services covered by Medicare Part D;
- Private-duty nursing;
- Personal Items;
- Additional costs for a non-medically necessary private room;
- Custodial care; and
- Long-term care.

Medicare Part B

Eligibility and Enrollment

Medicare Part B supplements the Part A benefit by covering physician charges and certain other services not covered under Part A. If you are receiving Social Security or Railroad Retirement benefits, you are eligible for Medicare Part B and can enroll during your initial enrollment period. Your initial enrollment period:

- Begins on the first of the month, three months before you reach age 65; and
- Ends seven months later.

You may enroll for Part B at any time during the seven-month initial enrollment period.

You also may be able to enroll for Part B during a Medicare special enrollment period. Call 800-MEDICARE or visit www.medicare.gov for more information about special enrollment periods.

Medicare Part D

If you enroll in the Medicare Advantage option, your coverage will include Medicare Part D prescription drug coverage and you cannot separately enroll in a Medicare Part D plan (including another group health plan that includes Medicare Part D coverage). Note that in addition to your contribution for coverage as described in the ***How Your Contribution for Coverage Is Determined*** section, depending on your yearly income you may be required to pay an extra amount for Medicare Part D coverage directly to the Social Security Administration. See <https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html> for more information.

If you enroll in the Medicare HMO option, your coverage will include prescription drug benefits that are, on average, at least as good as Medicare Part D prescription drug coverage. Therefore, if you enroll in the Medicare HMO option, you do not need to enroll in Medicare Part D to have prescription drug coverage.

If you do enroll in Medicare Part D (including another group health plan that includes Medicare Part D coverage), your eligibility for the Over-65 Retiree Plan will be terminated, and you will not be eligible to re-enroll in the Over-65 Retiree Plan at a future date.

JOINING THE OVER-65 RETIREE PLAN

There are two different circumstances under which you may enroll in the Over-65 Retiree Plan. You may enroll:

- When you are enrolled in the Medical Plan as a pre-65 Retiree, and you first become eligible to enroll in the Over-65 Retiree Plan; or
- When you retire on or after age 65 and you meet the eligibility requirements to enroll in the Over-65 Retiree Plan.

You may enroll your eligible spouse or Unrelated SDA under the same circumstances. In addition, you may enroll your eligible spouse or Unrelated SDA during the annual enrollment period, and you may be able to enroll your eligible spouse or Unrelated SDA mid-year if you experience an event that entitles you to a special enrollment period.

INITIAL ENROLLMENT

Individuals Who Retire Before Age 65

If you retire before age 65 and you are enrolled in the Medical Plan as a pre-65 Retiree, you will receive a letter informing you of your upcoming enrollment in the Over-65 Retiree Plan. You must return a copy of your Medicare card to the Benefits Department within 31 days of the date on which you turn 65 in order to complete your enrollment.

- If you were enrolled in the PPO option under the Medical Plan, you will be enrolled in the Medicare Advantage option under the Over-65 Retiree Plan. Enrollment in the Medicare Advantage plan cannot be completed without your Medicare number. You will be able to change your coverage election during the next annual enrollment period (or if you experience an event that entitles you to a Medicare special enrollment period. You also may make certain changes to your coverage during the annual Medicare Advantage disenrollment period.
- If you were enrolled in the HMO Illinois option under the Medical Plan, you will be enrolled in the Medicare HMO option under the Over-65 Retiree Plan. You will be able to change your coverage election during the next annual enrollment period (or if you experience a qualified change event that allows you to change your coverage elections mid-year, see ***Changing Your Coverage***).

Individuals Who Retire On or After Age 65

If you retire on or after age 65 and you are eligible for coverage under the Over-65 Retiree Plan, you will receive an enrollment kit in the mail at your home. You must complete the enrollment form(s) and return it to the Benefits Department within 31 days of your retirement date.

If you do not complete and return the form(s) by this deadline, you will waive your right to elect coverage under the Over-65 Retiree Plan, and you will not have another opportunity to enroll in the future.

Your Spouse or Unrelated SDA Who Is Age 65 and Entitled to Medicare

If your spouse or Unrelated SDA is age 65 or over and entitled to Medicare, he or she may continue medical coverage under the Over-65 Retiree Plan when you enroll in the Over-65 Retiree Plan. The necessary forms to complete to continue spouse or Unrelated SDA coverage will be included in your enrollment kit.

Your Other Eligible Dependents

To continue Medical Plan coverage for a spouse or Unrelated SDA who has not yet reached age 65 and become entitled to Medicare, or to continue Medical Plan coverage for an eligible dependent child or a Related SDA, you must complete and submit the required forms that are included in your enrollment kit (if applicable), or you may contact the Benefits Department to confirm that coverage will continue.

ANNUAL ENROLLMENT

Each fall, DePaul will offer an annual enrollment period, during which you will have the opportunity to change your coverage election under the Over-65 Retiree Plan for the next calendar year. DePaul will notify over-65 Retirees of the enrollment period and annual enrollment deadline, along with instructions about the forms and deadlines for changing coverage elections. Information about annual enrollment is available on the Human Resources website at <http://offices.depaul.edu/human-resources> 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, or a Medicare special enrollment event (for the Medicare Advantage option), as described in the Evidence of Coverage handbook. If you do not re-enroll during the annual enrollment period, you will continue to have the same coverage elections that you had in place the year before.

CHANGING YOUR COVERAGE

Once you enroll in the Over-65 Retiree Plan, you generally cannot change your coverage 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, you may be allowed to change your coverage elections outside of the annual enrollment period, if the change results from and is consistent with the qualified change event. You should contact the Benefits Department for more information and to request a *Flexible Benefits Enrollment – Family Status Change* form to complete and return. You must return the form (along with any required documentation) and request the change 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).

Qualified change events include:

- *HIPAA special enrollment – applies to dependent coverage elections only*
- *Qualified change in status*
- *Significant cost or coverage change*

Your election change will be effective as of the later of (1) the date on which you complete and return the *Flexible Benefits Enrollment – Family Status Change* form, or (2) the date of the qualified change event. You will have 31 days following the date of the qualified change event to provide any required supporting documentation to the Benefits Department.

Special Enrollment Rules – Changes to Dependent Coverage Elections Only

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

- You acquire a new dependent due to marriage, birth, adoption or placement for adoption;
- You declined coverage for your eligible dependent during a previous enrollment period because he or she was covered under another group health plan (or group health insurance), but he or she subsequently loses the other coverage for any of the following reasons:
 - He or she exhausts COBRA continuation coverage under the other 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
 - He or she loses eligibility under the other group health plan or health insurance coverage (other than due to a 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 after moving away from the service area;
 - In the case of a group HMO, loss of coverage after moving away from the service area, provided that no other benefit package is available;
 - He or she incurs a claim that meets or exceeds a lifetime limit on all benefits; or
 - Your dependent’s current employer decides to stop contributing for his or her coverage.
 - He or she 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 under Medicaid or a state child health plan.

If the Special Enrollment Right Is Due to Acquiring a New Dependent

When a 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 Medical Plan (or the Medicare HMO option under the Over-65 Retiree Plan, in the case of a spouse who has reached age 65 and become eligible for Medicare).

If your spouse is not already enrolled in the Medical Plan (or the Over-65 Retiree Plan, in the case of a spouse who has reached age 65 and become eligible for Medicare) and a special enrollment right arises because you acquire a new dependent, you can enroll your spouse in the Medical Plan (or the Medicare HMO option of the Over-65 Retiree Plan, as applicable) during the special enrollment period. However, you cannot enroll any other dependents who were already eligible for benefits but not previously enrolled for coverage.

Timing Rules for Requesting an Election Change

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

in coverage must be made within 60 days of the date your dependent loses coverage or becomes eligible for coverage, as applicable.

Change in Status Event

You may make a change to your coverage elections (under the Medical Plan and/or the Medicare HMO option of the Over-65 Retiree Plan, as applicable) 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 dependent's eligibility for Medical Plan coverage or coverage under 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 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, or any similar circumstance, in the Medical 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 (under the Medical Plan and/or the Medicare HMO option of the Over-65 Retiree Plan) outside of the annual enrollment period if:

- Your coverage or your dependents' coverage 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 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 plan has a different plan year or enrollment period than the Medical Plan and/or the Over-65 Retiree Plan.

If you are enrolled in the Medicare Advantage option, additional special enrollment period rules may apply, as described in the Evidence of Coverage handbook.

WHEN COVERAGE ENDS

Your coverage under the Over-65 Retiree Plan will end on the last day of the month in which any of the following occurs:

- you become eligible for Medical Plan benefits as an active employee of DePaul;
- the Over-65 Retiree Plan is terminated;
- you stop making the contributions needed to pay for your coverage;
- you enroll in Medicare Part D; you enroll in another plan that includes Medicare Part D; or
- you elect to terminate coverage under the Over-65 Retiree Plan.

If your coverage under the Over-65 Retiree Plan ends for any reason (other than if you are re-employed by DePaul as a full-time employee) you will not be allowed to re-enroll in the Over-65 Retiree Plan at any time in the future.

If your spouse or Unrelated SDA is covered under the Over-65 Retiree Plan, his or her coverage will end as of the date on which any of the following occurs:

- the Over-65 Retiree Plan is terminated;
- your spouse or Unrelated SDA ceases to meet the eligibility requirements;
- you stop making contributions needed to pay for your spouse's or Unrelated SDA's coverage;
- you elect to terminate coverage for your spouse or Unrelated SDA under the Over-65 Retiree Plan;
- your spouse enrolls in Medicare Part D;
- your spouse enrolls in another plan that includes Medicare Part D; or
- your coverage ends for any reason other than due to your death.

If you are enrolled in the Medicare Advantage option, Medicare requires your coverage to end in certain circumstances in addition to those listed above, as described in the Evidence of Coverage handbook.

Rescission of Coverage

Your Over-65 Retiree 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 Over-65 Retiree 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 Over-65 Retiree Plan claims procedures. A retroactive termination due to your non-payment of contributions is not considered a rescission.

Note about Continuing Coverage

Refer to ***Continuing Coverage after Plan Coverage Ends*** below, or contact the Benefits Department to find out more about available coverage continuation options.

CONTINUING COVERAGE AFTER PLAN COVERAGE ENDS

COBRA

If your spouse loses coverage under the Over-65 Retiree Plan as the result of divorce, he or she may be eligible to continue benefits coverage at his or her own expense for up to 36 months, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"). In accordance with the rules described below, your spouse will be provided with information and an opportunity to continue coverage under the Over-65 Retiree Plan program option in which he or she is enrolled at the time of your divorce.

Coverage Options other than COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for your spouse through the Health Insurance Marketplace, Medicaid 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.

Notice Requirement and Electing Continuation Coverage

You or your spouse must inform the Benefits Department within 60 days of the last day of the month in which your divorce occurs to request notice of COBRA continuation rights. You may provide notice orally, electronically or in writing. If you do not give notice within the required time period, your spouse may not elect continuation coverage. If you provide timely notice of divorce, the COBRA administrator will notify your spouse of his or her right to continue coverage and provide your spouse with the necessary information to complete an election. Your spouse will have 60 days from the later of the date coverage is lost, or the date the notice of the right to continue coverage is received, whichever date is later, to elect continuation coverage. If the election is not completed within the 60-day period, your spouse 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, your spouse will not have any coverage until he or she elects continuation coverage and pays the required premiums. This means no claims will be paid during the election period. In order to receive uninterrupted coverage, your spouse should elect continuation coverage and make the required premium payments as soon as possible after receiving the notice of continuation coverage. See ***Cost of COBRA Continuation Coverage*** below.

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.

Cost of COBRA Continuation Coverage

The cost for continuation coverage is 102% of the full cost for providing coverage to a similarly situated dependent. However, if you are enrolled in the Medicare Advantage option when a qualifying event occurs, the cost of COBRA coverage may be limited by rules applicable to Medicare premiums. Your spouse's first payment is due 45 days after his or her election and must cover the period of time back to the first day of COBRA continuation coverage. Subsequent payments are due once a month. Payment coupons will be sent to your spouse after he or she elects continuation coverage. If the COBRA Administrator does not receive your spouse's monthly contribution within 30 days of the due date, continuation coverage will be canceled as of the last day of the month in which a contribution was received.

If your spouse qualifies for coverage continuation under COBRA, he or she may elect to continue the coverage in effect at the time his or her regular coverage ends but may not change his or her coverage election. Following your spouse's initial enrollment in COBRA continuation coverage, he or she may change coverage elections during the next annual enrollment period, or if he or she experiences a qualified change event.

Termination Before the End of the Maximum Coverage Period

Normally, your spouse's continuation coverage may be continued for up to 36 months, as long as your spouse makes 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 or retirees;
- Your spouse fails to pay the premium for the continuation coverage elected within 30 days of the first day of the month; or
- After continuation coverage is elected, your spouse becomes 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.

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.

Illinois Continuation Coverage for Medicare HMO Option

If you participate in the Medicare HMO option, then you and your spouse or Unrelated SDA may have special Illinois continuation 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).

PROGRAM DETAILS

Over-65 Retiree Plan Options

There are two program options under the Over-65 Retiree Plan, both of which are administered by BCBS:

- **Medicare Advantage Option**
- **Medicare HMO Option**

Covered Health Services

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

- considered "**Covered Health Services**" (refer to the *Important 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 *Important 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 *Medicare Advantage Option* and *Medicare HMO Option* sections.

Only health care services that are described in this *Covered Health Services* section are covered under the Over-65 Retiree 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 Over-65 Retiree Plan.

For additional information, or for a list of services that are covered under the Medicare Advantage option, you should call BCBS directly at 1-877-299-1008.

Covered Providers

Refer to the definition of "**Provider**" in the *Important Definitions* section. To determine if a particular provider "type" or provider "class" is covered, you should contact BCBS directly at 1-877-299-1008, or sign in as a member at www.bcbsil.com and select "View Medical Coverage."

Medicare Advantage Option

The Medicare Advantage option is a fully insured Medicare product that is offered through BlueCross BlueShield of Illinois (“BCBS”), which means that BCBS insures and funds all benefits under this option. While the Medicare Advantage option covers many medical services and supplies, you will be responsible for a portion of those expenses such as the Co-payment, Deductible and Co-Insurance, as explained below. If you enroll in the Medicare Advantage option, your Medicare benefits (including Part D prescription drug benefits) are provided through this coverage option.

Medicare Advantage Option – Schedule of Benefits*

DEDUCTIBLE: Per individual, per calendar year.*	\$200
FAMILY DEDUCTIBLE:	N/A – each member must satisfy individual deductible separately
OUT-OF-POCKET MAXIMUM: The amount of money an individual pays toward covered health care expenses during any calendar year. Certain items are not applied towards the out-of-pocket maximum limit: <ul style="list-style-type: none"> • Co-payments and coinsurance for prescription expenses • Charges from providers who do not accept Medicare assignment 	\$2,000 / Individual each member is subject to individual out-of-pocket maximum limit Note: Out-of-pocket expense limitation includes both medical and Rx. Medical = \$1,000 Rx = \$1,000
PREVENTIVE CARE: The Medicare Advantage 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)
INPATIENT SERVICES <ul style="list-style-type: none"> • HOSPITAL: Includes hospital, coordinated home care, hospice, skilled nursing. Room allowances are based on the hospital’s most common semi-private room rates • INPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY: Paid the same as any other inpatient service. 	96%
OUTPATIENT SERVICES <ul style="list-style-type: none"> • HOSPITAL: Including radiation, chemotherapy, renal dialysis. • OUTPATIENT SURGERY: Hospital & Physician. • OUTPATIENT DIAGNOSTIC TESTS including x-rays, blood tests, CAT scans, MRIs, diagnostic mammograms and PSA tests performed at a hospital. • OUTPATIENT REHABILITATION: Includes Cardiac/Pulmonary, physical therapy, occupational therapy, speech therapy, and chiropractic services. Physical therapy, speech-language pathology services, and occupational therapy are subject to annual dollar limits. In 2017, the limit applicable to physical therapy and speech-language pathology services (combined) is \$1,980, and the limit applicable to occupational therapy is \$1,980. • OUTPATIENT MENTAL HEALTH/CHEMICAL DEPENDENCY: Paid the same as other outpatient services. 	96%
THERAPY SERVICES: Coverage for services provided by a physician or therapist, including speech, occupational and physical therapy.	\$40 co-pay
MUSCLE MANIPULATION SERVICES: Coverage for spinal and muscle manipulation services provided by a physician or a chiropractor (for Medicare approved services).	\$20 co-pay for Medicare Approved Services
PROFESSIONAL OFFICE VISITS	Primary Care Office Visit: \$20 co-pay Specialty Care Office Visit: \$40 co-pay
MEDICAL SUPPLIES	96%
EMERGENCY: (Hospital) Emergency Medical and Emergency Accident - Initial treatment in hospital of accidental	\$65 co-pay

injuries or sudden and unexpected medical conditions following the standard emergency criteria.	Ambulance Services: 96%
<p>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 available for 1-month or 3-month supply; benefits for mail order drugs are available for 3-month supply.</p>	<p style="text-align: center;">Retail</p> <p>1-month supply: You pay 20% (\$10 min, \$100 max)</p> <p>2-month supply: You pay 20% (\$20 min, \$200 max)</p> <p>3-month supply: You pay 20% (\$30 min, \$300 max)</p> <p style="text-align: center;">Mail Order</p> <p>You pay the applicable 30, 60, or 90 day co-pay:</p> <p>Tier 1 and 2: Generic \$10 (30 or 60 day), \$25 (90 day)</p> <p>Tier 3: Preferred Brand \$30 (30 or 60 day), \$60 (90 day)</p> <p>Tier 4: Non-Preferred Brand \$50 (30 or 60 day), \$100 (90 day)</p> <p>Tier 5: Specialty: You pay 20%</p>
<p>PRE-EXISTING CONDITIONS WAITING PERIOD: None</p>	
<p>COORDINATION OF BENEFITS: This program coordinates benefits with other group plans.</p>	

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

How the Medicare Advantage Option Works

If you have medical expenses, the Medicare Advantage option may cover all or part of the expenses based on the provisions in this section and this SPD. You may obtain services from any provider that accepts Medicare.

Your Co-payments

Your Co-payment is a set dollar amount you pay for certain services. You will be required to pay the established amount each time you obtain services or supplies for which a Co-payment is required. Co-payments do not apply to the annual deductible.

Annual Deductible

The Deductible is the portion of your eligible expenses you pay each calendar year before the Over-65 Retiree Plan pays benefits. Each individual who is covered under the Medicare Advantage option must satisfy the annual deductible separately. The Deductible does not apply toward the Out-of-Pocket Maximum.

Your Co-Insurance and Annual Out-of-Pocket Maximum

Once you meet the Deductible, where applicable, the Over-65 Retiree Plan will pay a percentage of eligible expenses for you and your spouse or Unrelated SDA (if he or she is covered under the Over-65 Retiree Plan). You pay the remaining portion of the eligible expenses, which is called Co-insurance.

As added financial protection for you, the Medicare Advantage option limits the amount that you will have to pay out of your own pocket for covered medical expenses each year. Once you have satisfied your Deductible and have reached the annual Out-of-Pocket Maximum, the Plan will pay 100% of covered medical expenses for the remainder of the year. The annual Out-of-Pocket Maximum does not carry over to the following year.

The following expenses do not apply toward the Out-of-Pocket Maximum and will not be paid at 100% after you reach your Out-of-Pocket Maximum:

- Your annual Deductible;
- Any unreimbursed expense incurred for covered services received in a prior plan year, that is paid by you during the current plan year.

A separate Out-of-Pocket Maximum applies to covered prescription drug expenses, as indicated in the ***Schedule of Benefits***.

Special Note about Annual Deductible and Out-of-Pocket Maximum for Certain Retirees

If you are a Retiree who satisfies the requirements for Grandfathered Group – Category One, you moved from the Medicare Supplement option to the Medicare Carve-Out option as of January 1, 2011, and you moved from the Medicare Carve-Out option to the Medicare Advantage option as of January 1, 2017, you will not be required to meet the annual deductible under the Medicare Carve-Out option. You also will be treated as if you have already met the Out-of-Pocket Maximum (as described above) as of the first day of each plan year.

Special Benefit Maximums – Cardiac Rehabilitation Services

Cardiac rehabilitation services are subject to certain limitations. Specifically, benefits are available only when such services are rendered within the six-month period following an eligible inpatient hospital admission for either myocardial infarction, coronary artery bypass surgery or percutaneous transluminal coronary angioplasty.

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.”

Procedures for Obtaining Health Services

All coverage is subject to the provisions of this section and other limitations and exclusions of the Over-65 Retiree Plan.

Covered Health Services

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.

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

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 four prescription drug programs, described below, which include additional requirements:

Prior Authorization Program – The Medicare Advantage option requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from BCBS before you fill your prescriptions. If you don't get approval, the Plan may not cover the drug.

- 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
- For more information about the prescription drugs included in the Prior Authorization Program and the steps that need to be taken to request prior authorization, visit bcbsil.com/member/rx_drug_choices.html, select your applicable plan coverage, and scroll down to the Prior Authorization/Step Therapy Program section,

Quantity Limits – For certain drugs, the Medicare Advantage option limits the amount of the drug that the Plan will cover. (For example, the Medicare Advantage option provides 30 tablets per prescription for alfuzosin ER. This may be in addition to a standard one-month or three-month supply.)

Step Therapy Program – In some cases, the Medicare Advantage option requires you to first try certain drugs to treat your medical condition before the Plan will cover another drug for that condition. (For example, if Drug A and Drug B both treat your medical condition, the Medicare Advantage option may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B.)

- Examples of Medication Categories Included in the Step Therapy Program
 - antidepressants
 - diabetes
 - lipid management
 - proton pump inhibitors
 - biological immunomodulators
 - iron chelators
 - multiple sclerosis
 - atopic dermatitis
 - fibrate
 - ophthalmic prostaglandins/glaucoma

Prime Specialty Pharmacy Program – Under this program, you are required to obtain specialty medications through Prime Specialty Pharmacy, which will coordinate filling your prescription and ship your medication overnight. Specialty medicines are generally higher-cost medicines that require extra support to manage and administer. These medicines are used to treat chronic (long-term) and complex conditions.

- General Program Rules
 - For specialty medications, you will need to contact Prime Specialty Pharmacy to set up your prescription and delivery. You can reach them at 877 627-6337 with questions or for help. Pharmacy hours are 7:00AM to 7:00PM Central time, Monday through Friday.
 - 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 Step Therapy Program and the Prime Specialty Pharmacy Program are subject to periodic review and modification by BCBS. For the most current lists, visit BCBS'

website at www.getblueil.com/mapd/druglist or call Blue Cross Medicare Advantage Customer Service at 1-877-774-8592 or, for TTY/TDD users, 711.

Transition Refill – As a new Participant in the Medicare Advantage option you may be taking drugs that are not on the formulary. Or, you may be taking a drug that is on the formulary but your ability to get it is limited. For example, you may need a prior authorization from BCBS before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that is covered or request a formulary exception so that the Medicare Advantage option will cover the drug you take. While you talk to your doctor to determine the right course of action for you, the Medicare Advantage option may cover your drug in certain cases during the first 90 days you are enrolled.

For each of your drugs that is not on the formulary or if your ability to get your drugs is limited, the Medicare Advantage option will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, the Plan will not pay for these drugs, even if you have been participating in the Plan less than 90 days.

If you are a resident of a long-term care facility, the Plan will allow you to refill your prescription until you have received a maximum 98-day transition supply, consistent with dispensing increment, (unless you have a prescription written for fewer days). The Plan will cover more than one refill of these drugs for the first 90 days if you are a Participant in the Medicare Advantage option. If you need a drug that is not on the formulary, or if your ability to get your drugs is limited, but you are past the first 90 days of participation in the Medicare Advantage option, the Plan will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

You may have changes that take you from one treatment setting to another. During this level of care change, drugs may be prescribed that are not covered by the Plan. If this happens, you and your doctor should refer to the **Coverage Decisions and Appeals** section of the Evidence of Coverage handbook for information on how to appeal the decision.

You can find out if your drug has any additional requirements or limits by looking in the Formulary for the Medicare Advantage option. You can also get more information about the restrictions applied to specific covered drugs by visiting the BCBS website at www.getblueil.com/mapd/druglist or calling Blue Cross Medicare Advantage Customer Service at 1-877-774-8592 or, for TTY/TDD users, 711. BCBS has posted online documents that explain the Prior Authorization and Step Therapy restrictions.

What is the Medicare Advantage Option Formulary?

A formulary is a list of covered drugs selected by BCBS in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The Medicare Advantage option will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Medicare Advantage option network pharmacy, and other Plan rules are followed. For more information on how to fill your prescriptions and what steps you may take if your drug is not on the Formulary, please review your Evidence of Coverage handbook. All drugs included in this formulary are available via mail-order benefit. Contact BCBS for details.

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 Medicare Advantage 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 Over-65 Retiree Plan procedures, coverage of benefits may be denied.

Emergency Health Services

The Medicare Advantage option provides coverage of 100% of eligible expenses for emergency health services (after co-payment), without regard to whether you obtain such services from an in-network hospital or an out-of-network hospital. In order for such health services to be considered eligible expenses under the Medicare Advantage option, the health services must meet the definition of "Emergency Health Services" as described in the **Important Definitions** section.

General Exclusions

The following services are not covered under the Medicare Advantage option; however, this list may not be exhaustive. For a complete, current list of services and supplies excluded from coverage under the Medicare Advantage option, 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.

- Hospitalization, services or supplies which are not Medically Necessary;
- Services considered not reasonable and necessary, according to the standards of Original Medicare;
- Services or supplies that do not meet accepted standards of medical practices;
- Custodial Care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care;
- Respite Care Service, except as specifically mentioned under the Hospice Program;
- Inpatient Private Duty Nursing Service;
- Cosmetic surgery or procedures except in cases of an accidental injury or for improvement of the functioning of a malformed body member and covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones;
- Eyeglasses, contact lenses or cataract lenses and examination for prescribing or fitting of glasses or contact lenses or for determining the refractive status of the eye, except as specifically mentioned in this SPD;
- Routine foot care;
- Immunizations, unless covered by Medicare Part B or Part D;
- Diagnostic Services as part of routine physical examination or check-ups, , determination of the refractive error of the eyes
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient or unrelated to the treatment of a disease or injury;
- Private room in a hospital covered only when medically necessary.
- Full-time nursing care in your home.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged for care by your immediate relatives or members of your household.
- Routine dental care, such as cleanings, fillings or dentures (except in cases where dental care is required to treat illness or injury may be covered as inpatient or outpatient care.)
- Routine chiropractic care except in cases where manual manipulation of the spine to correct a subluxation.
- Routine foot care (Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.)
- Home-delivered meals
- Orthopedic shoes except in cases where the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids, except where otherwise noted in Evidence of Coverage handbook.
- Reversal of sterilization procedures and or non-prescription contraceptive supplies.

- Acupuncture
- Naturopath services (uses natural or alternative treatments).

Medicare HMO Option

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

Benefits under the Medicare HMO option are coordinated with your Medicare benefit (Parts A and B) to provide you (and your spouse or Unrelated SDA, as applicable) with comprehensive medical coverage. The Medicare HMO option also provides a prescription drug benefit.

Medicare HMO Option – 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 Medicare HMO 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, coordinated home care, skilled nursing facility, hospice care, and Outpatient surgery (hospital and physician charges).	100% after \$250 Hospitalization Co-pay	Not covered
INPATIENT SERVICES <ul style="list-style-type: none"> INPATIENT MENTAL HEALTH AND CHEMICAL DEPENDENCY/SUBSTANCE ABUSE: Paid the same as any other inpatient admission. 	100%	Not covered
OUTPATIENT SERVICES <ul style="list-style-type: none"> OUTPATIENT MENTAL HEALTH AND CHEMICAL DEPENDENCY/SUBSTANCE ABUSE: Paid the same as any other outpatient condition. 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 \$35 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 \$35 co-pay only applies to the first visit.	\$35 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	100%	100%

injuries or sudden and unexpected medical conditions following the standard emergency criteria.	after \$75 Co-pay (waived if admitted)	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 available at select Retail Stores.	<p>Retail Generic: You pay 20% (\$10 min, \$100 max)</p> <p>Formulary: You pay 30% (\$10 min, \$125 max)-</p> <p>Non-Formulary: You pay 35% (\$10 min, \$150 max)</p> <p>Mail Order Co-pay: \$25 generic \$60 formulary \$100 non-formulary</p> <p>For retail, if the cost of the prescription is less than the minimum co-insurance amount, you pay only the cost of the prescription.</p>	Not covered
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		
COORDINATION OF BENEFITS: This program coordinates benefits with other group plans.		

How the Medicare HMO Option Works

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

The Medicare HMO 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 PCP or Woman’s Principal Health Care Provider except for emergency health services, substance abuse services, and 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 BCBS, and, if necessary, BCBS can assist you in finding 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 Over-65 Retiree Plan benefits and provisions.

Your Co-payment

Your co-payment is the charge that you are required to pay for certain health services provided under the Medicare HMO 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 Medicare HMO 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 Over-65 Retiree Plan pays 100% of most eligible medical expenses, including the co-payment.

Special Benefit Maximums

Certain specific benefits may be subject to special benefit maximums that limit the number of treatments/visits to a treatment facility that the Over-65 Retiree Plan will cover. Expenses for services that exceed the special benefit maximum are not covered under the Medicare HMO option.

The following medical care is subject to special benefit maximums:

- Outpatient rehabilitative therapy
- Outpatient speech therapy

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 800-892-2803 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 Over-65 Retiree Plan.

Enrolling for coverage under the Medicare HMO 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 Medicare HMO option and payment of the co-payment specified for any service.

Special Note Regarding Prescription Drug Coverage

Certain prescription drugs require prior authorization by the pharmacist or the prescribing physician from the Plan or its designee prior to dispensing. There are two Medicare HMO programs that require prior authorization:

Prior Authorization Program – The Medicare HMO option requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from BCBS before you fill your prescriptions. If you don't get approval, the Plan may not cover the drug.

- 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
- For more information about the prescription drugs included in the Prior Authorization Program and the steps that need to be taken to request prior authorization, 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 – In some cases, the Medicare HMO option requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. (For example, if Drug A and Drug B both treat your medical condition, the Medicare Advantage option may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B.)

- Examples of Medication Categories Included in the Step Therapy Program
 - antidepressants
 - diabetes
 - lipid management
 - proton pump inhibitors
 - biological immunomodulators
 - iron chelators
 - multiple sclerosis
 - atopic dermatitis
 - fibrate
 - ophthalmic prostaglandins/glaucoma

The lists of prescription drugs included in the Prior Authorization Program and the Step Therapy Program are subject to periodic review and modification by the Medicare HMO. 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.

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. Specialty medicines are generally higher-cost medicines that require extra support to manage and administer. These medicines are used to treat chronic (long-term) and complex conditions.

- General Program Rules
 - For specialty medications, you may contact Prime Specialty Pharmacy to set up your prescription and delivery. You can reach them at 877 627-6337 with questions or for help. Pharmacy hours are 7:00AM to 7:00PM Central time, Monday through Friday.
 - 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, visit BCBS' website at www.getblueil.com/mapd/druglist or call Blue Cross Medicare Advantage Customer Service at 1-877-774-8592 or, for TTY/TDD users, 711.

Selection of a Primary Physician

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

If you elect coverage for your spouse under the Medicare HMO option, he or she may select a different participant IPA and PCP or Participating Medical Group. Your spouse must choose a PCP 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 spouse (as applicable). For more information on how to select a PCP, contact BCBS at 800-892-2803 or sign in as a member at www.bcbsil.com and select "View Medical Coverage."

You do not need prior authorization from BCBS 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 BCBS at 800-892-2803 or sign in as a member at www.bcbsil.com and select "View Medical Coverage."

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 under the Medicare HMO option, 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 Medicare HMO 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 Over-65 Retiree 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 BCBS 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 BCBS 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 BCBS 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.

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. 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. 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 Medicare HMO option and you move out of the HMO service area, you may elect coverage under any other available program option under the Over-65 Retiree Plan. You may also change your coverage category, if applicable. You must contact the Benefits Department and complete a status change application within 31 days of the move.

Vision Care Benefits

Your Medicare HMO coverage includes benefits for the following vision care:

- Lenses; and
- Frames or Contact Lenses.

Benefits are provided for lenses, and either one set of frames or one pair of contact lenses, obtained through a Participating Vision Care Provider each 24-month benefit period. Benefits will be provided for additional lenses during a benefit period, subject to the total benefit maximum per benefit period, if required because the prescription for the lenses has changed.

How Vision Care Benefits Are Paid

100% of the provider's charge will be paid for lenses; 100% of the provider's charge will be paid for frames or contact lenses up to a total maximum per benefit period of \$75.

Special Limitations on Vision Care Benefits

Your vision care coverage does not include benefits for:

- Recreational sunglasses;
- Orthoptics, vision training, subnormal vision aids, aniseikonic lenses or tonography;
- Additional charges for tinted, photo-sensitive or anti-reflected lenses beyond the benefit allowance for standard lenses; or
- Replacement of lenses, frames or contact lenses that are lost or broken, unless such lenses, frames or contact lenses would otherwise be covered according to the benefit period limitations specified above.

General Exclusions

The following services are not covered under the Medicare HMO option; however, this list may not be exhaustive. For a complete, current list of services and supplies excluded from coverage under the Medicare HMO option, 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.

- Services or supplies that are not specifically stated in this document.

- Services or supplies that were not ordered by your Primary Care Physician or Woman's Principal Health Care Provider except as explained in this **Medicare HMO Option** section of the SPD.
- Services or supplies that were received prior to the date your coverage began or after the date that your coverage was terminated.
- Services or supplies for which benefits have been paid under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any business or enterprise, defined as a "small business" under paragraph (b), Section 3 or the Illinois Small Business Purchasing Act, as amended, and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and services or supplies to the extent payments or benefits for such services or supplies are provided by or available from the local, state or federal government (for example, Medicare) whether or not those payments or benefits are received, except, however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI, or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 1-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- 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 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 Investigational in nature.
- Custodial Care Services.
- Long Term Care Services.
- Respite Care Services, except as specifically mentioned in the HMO Illinois Certificate.
- 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.
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease.
- Services or supplies received from a dental or medical department or clinic maintained by an employer, labor union or other similar person or group.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form or charges for the transfer of medical records.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus or, battery implants except as specifically stated in the HMO Illinois Certificate.
- Prosthetic devices, special appliances or surgical implants which are for cosmetic purposes, the comfort or convenience of the patient or unrelated to the treatment of a disease or injury.
- Nutritional items such as infant formula, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins and herbal supplements.
- Blood derivatives which are not classified as drugs in the official formularies.
- Marriage counseling.
- Hypnotism.
- Inpatient and Outpatient Private Duty Nursing Service.
- Routine foot care, except for persons diagnosed with diabetes.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.
- Maintenance Care.
- Self-management training, education and medical nutrition therapy, except as specifically stated in this document.

- Services or supplies which are rendered for the care, treatment, filling, removal, replacement or artificial restoration of the teeth or structures directly supporting the teeth except as specifically stated in this document.
- 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.
- Services or supplies rendered for human organ or tissue transplants except as specifically provided for in this document.
- Wigs (also referred to as cranial prostheses).
- Elective abortions.

Medicare HMO Conversion Privilege

If, at the time that your coverage under the Over-65 Retiree Plan is terminated, you have been covered for at least three months as an Eligible Person in the Medicare HMO option (or, in the case of your spouse, as an eligible dependent), you may convert your coverage to the coverage that the Plan has available for persons who are no longer members of a group.

In order to convert your coverage you should:

- Contact the Plan Administrator to get an application.
- Send the application to the Plan within 31 days of the date that your coverage is terminated.

Having done so, you will then be covered by the Plan on an individual direct-payment basis. Your converted coverage will be effective from the date that your Group coverage terminates as long as you pay the required premiums when due.

The converted coverage may require co-payments and/or deductibles that are different from those shown in this document. The converted coverage will provide, at minimum, benefits for basic health care services as defined in the HMO Act.

The Plan is not required to offer conversion coverage to you if you no longer live within the service area of a Participating IPA or Participating Medical Group. However, if you have similar benefits under a group arrangement that does not cover pre-existing conditions, and you have a pre-existing condition, you can continue conversion coverage until your pre-existing condition is covered under that group arrangement.

Conversion coverage is not available when your Group terminates its coverage under the HMO Illinois Certificate and replaces it with other coverage or when your coverage has been terminated for failure to pay a required premium or charge; or for fraud or material misrepresentation in enrollment or in the use of services or facilities.

Different rules regarding conversion coverage may apply for your Unrelated SDA. For more information about conversion rights for your Unrelated SDA, you should refer to your HMO Illinois Certificate (or call BCBS at 800-458-6024).

Identification Cards for the Over-65 Retiree Plan Program Options

When you enroll in one of the Over-65 Retiree 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 Over-65 Retiree 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 the 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.

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 Over-65 Retiree 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 co-insurance that are applicable to medical and surgical benefits provided by this 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.

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 Notice of Privacy Practices (the "Notice") for the Over-65 Retiree Plan. 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 DePaul contain standards designed to maintain the security of your PHI.

IMPORTANT DEFINITIONS

As you read about your benefits, you may encounter terms that have specific meanings under the Over-65 Retiree Plan. This section defines certain important terms. Any term not included in this section, but

used in this summary shall have the same meaning as specified in the Plan or the underlying documents for the Medicare Advantage option and the Medicare HMO option.

Chemical Dependency Treatment - an organized, intensive, structured rehabilitative treatment program of either a Hospital or a Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court ordered evaluations, programs primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Claims Administrator - Blue Cross and Blue Shield of Illinois.

Claim Charge - the amount that appears on a claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

Co-Insurance - the applicable percentage of benefit costs in excess of the Deductible, if any, which you must pay yourself, as set forth in each Plan's Schedule of Benefits.

Coordinated Home Care Program means an organized skilled patient care program in which care is provided in the home. Such home care must be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound and you must require Skilled Nursing Services on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of a registered professional nurse, and the services of physical therapist, hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Co-payment - the specified dollar amount that you must pay, in conjunction with the receipt of Covered Services specified under the terms of each of the program options.

Covered Services - those services and supplies specified under the terms of each of the medical coverage options offered under the Over-65 Retiree Plan.

Custodial Care Service - those services which do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed services and supplies (including room and board) which do not contribute greatly to the improvement of a medical condition according to generally accepted standards and which can safely and adequately be given by people who are not trained or licensed medical personnel. Custodial Care includes, but is not limited to:

- Assisting the person to work, get in and out of bed, bathe or dress;
- Preparation of special diets;
- Supervision of medicine, which can usually be self-administered and which does not require the attention of medical or paramedical personnel; and
- Assisting the person with other activities of daily life.

Such care is custodial without regard to the Provider by which it is prescribed, referred or performed.

Deductible - the specified dollar amount of eligible expenses, set forth in the Schedule of Benefits for each medical coverage option, which must be paid by you, each calendar year, prior to becoming eligible for any reimbursement under the Over-65 Retiree Plan.

Diagnostic Service - tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, X-rays,

pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Emergency Accident Care - the initial Outpatient treatment of accidental injuries including related Diagnostic Service

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.

Generic Drug - a pharmaceutical product manufactured and sold under its chemical or “common” name, rather than the name chosen by the manufacturer. The same active ingredients go into a Generic Drug as go into its brand name counterpart.

HIPAA - the federal Health Insurance Portability and Accountability Act, which is far-reaching legislation designed to improve the portability of health coverage and to make other changes to the health care delivery system.

Hospital - a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes Skilled Nursing Facilities, convalescent homes, custodial homes of the aged or similar institutions.

Insurer - Blue Cross Blue Shield of Illinois.

Inpatient - that you are a registered bed patient and are treated as such in a health care facility.

Investigational (or Experimental) Services and Supplies - drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness and/or (2) 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 you and (3) specifically with regard 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 you.

Long-Term Care Services - those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of chronic illness, injury or condition.

Maintenance Care - those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of a condition is expected to occur.

Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy - therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition is expected to occur.

Maternity Service - the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

Medical Care - the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

Medically Necessary - includes 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 - Title XVII (Health Insurance for the Aged) of the United States Social Security Act, as amended from time to time.

Mental Illness - an illness classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

Occupational Therapy - constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adopted to develop a physical function.

Ongoing Course of Treatment - the treatment of a condition or disease that requires repeated health care services pursuant to a plan of treatment by a Physician because of the potential for changes in the therapeutic regimen.

Optician - a duly licensed Optician.

Optometrist - a duly licensed Optometrist.

Outpatient - that you are receiving treatment while not an Inpatient.

Plan Sponsor - DePaul University. DePaul University is also the Plan Administrator.

Pharmacy - any licensed establishment in which the profession of pharmacy is practiced.

Physical Therapist - a duly licensed Physical Therapist.

Physical Therapy - the treatment by physical means by a Physician or a registered professional physical therapist under the supervision of either a Physician or qualified Physical Therapist, depending on the terms of the Over-65 Retiree Plan.

Physician - a Physician duly licensed to practice in all of its branches.

Primary Care Physician - a Provider who is a member of employee of or who is affiliated with or engaged by an organization that has an agreement with the Insurer to provide services under one of the Over-65 Retiree Plan.

Private Duty Nursing Service - a skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practice nurse who is not providing this service as an employee or agent of a Hospital or other health care facility. Private Duty Nursing Service does not include Custodial Care Service.

Provider - any health care facility, institution, organization or person that furnishes Covered Services to you.

Psychologist - a Registered Clinical Psychologist in the state in which the treatment occurs.

Respite Care Services - those services provided at home or in a facility to temporarily relieve the family or other caregivers that provide or are able to provide such services.

Skilled Nursing Facility - an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by an appropriate governmental authority to provide such services. It does not mean institutions which provide only minimal care, Custodial Care Services, ambulatory or part-time care services or institutions which primarily provide for the care and treatment of Mental Illness, pulmonary tuberculosis or Substance Abuse.

Skilled Nursing Service - those services provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Skilled Nursing Service does not include Custodial Care Service.

Speech Therapy - the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adopted to promote the restoration of useful physical function. Speech Therapy does not include educational training or services designed and adopted to develop a physical function.

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 the Over-65 Retiree Plan.

Substance Abuse - the uncontrollable or excessive abuse of addictive substances containing alcohol, morphine, cocaine, heroin, opium, cannabis and other barbiturates, tranquilizers, amphetamines and/or hallucinogens and resultant physiological and/or psychological dependency (which develops with continued use of such additive substances) requiring Medical Care as determined by a Physician or Psychologist.

Substance Abuse Treatment Facility - a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by an appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide a supportive environment, even if counseling is provided in such facilities.

Surgery - the performance of any, medically recognized non-Experimental surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations any other procedures as reasonably approved by the Claims Administrator or the Insurer, as appropriate.

Temporomandibular Joint Dysfunction and Related Disorders - jaw joint conditions including Temporomandibular joint disorders and craniomandibular disorders, and other conditions of the joint linking the jaw bone and skull and the muscles, nerves and other tissues relating to that joint.

Vision Care Provider - any individual, partnership, proprietorship or organization lawfully and regularly engaged in the business of prescribing and/or dispensing corrective lenses prescribed by a Physician, Optometrist or Optician.

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

HOW THE OVER-65 RETIREE PLAN WORKS WITH OTHER PLANS

If you or your spouse or Unrelated SDA is covered by the Over-65 Retiree Plan and another medical plan, Over-65 Retiree Plan 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 provision, one plan is considered primary and the other plan is considered secondary. If the Over-65 Retiree Plan is not primary, DePaul will pay the difference (if any) between the amount that would have been paid if the Over-65 Retiree Plan was primary, and the amount that the primary plan actually paid (or would have paid if primary coverage is assumed). Neither the primary plan nor the secondary plan will pay more than it would without the coordination provision.

Rules to Determine Payment Responsibility for the Medicare HMO Option

If you are enrolled in the Medicare HMO option, you can determine whether the Over-65 Retiree Plan or another plan pays primary by using the following rules:

- If one plan does not have a Coordination of Benefits ("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 first, and the plan that covers the individual as a dependent will pay second.
- 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.

Benefits Coordination with Medicare

If you are enrolled in the Medicare HMO option, coverage is coordinated with Medicare. When determining how much the Over-65 Retiree Plan will pay for Covered Services, the Plan assumes that you have coverage under Medicare Part A and Part B, whether or not you have actually enrolled for full coverage.

If you are enrolled in Medicare Part A and Part B, Medicare will pay benefits before the Over-65 Retiree Plan pays. If you are not enrolled in full coverage under Medicare, the Plan will take the following steps to determine how much it will pay for your Covered Services:

- Determine what the payment for Covered Services would be according to the payment provisions under the Medicare HMO option.
- Deduct the amount that would be paid by Medicare (if you had enrolled in full coverage under Medicare) from the payment amount determined as described above.

The resulting difference, if any, is the amount that the Plan will pay towards the cost of the Covered Services.

Rules to Determine Payment Responsibility for the Medicare Advantage Option

If you are enrolled in the Medicare Advantage option and another plan, whether the Over-65 Retiree Plan or the other plan pays primary will be determined in accordance with the Medicare Secondary Payer rules. You can refer to your Evidence of Coverage handbook for more information.

RECEIVING YOUR BENEFITS – CLAIMS AND APPEALS PROCEDURES FOR THE MEDICARE HMO OPTION

If you are enrolled in the Medicare HMO option, to receive your benefits under the Over-65 Retiree Plan, 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 <http://offices.depaul.edu/human-resources>, or you can contact the Benefits Department directly to request the form. DePaul has delegated full discretion, authority, and fiduciary responsibility for claims and appeals decisions to the claims administrators for the Plan, excluding issues of eligibility which will be decided by the Benefits Department.

Claims Related to Eligibility

Claims that relate solely to whether you are eligible to participate in the Over-65 Retiree Plan, and that do not involve a claim for benefits under the Over-65 Retiree Plan, 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 Over-65 Retiree Plan, including a claim for benefits that requires an eligibility determination in order to determine whether an individual may receive benefits under the Over-65 Retiree Plan, should be made to the proper claims administrator in accordance with the claims filing procedures as described below.

Submitting Claims

The claims administrator will process the claim and send you an Explanation of Benefits, 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 the provider any amounts not covered under the Over-65 Retiree Plan.

Claims fall into one of four categories: post-service, pre-service, urgent care and concurrent. Claims for Over-65 Retiree Plan benefits will be administered by the appropriate claims administrator.

Claims for Outpatient Prescription Drugs

- Complete an *Outpatient Prescription Drug Claim* form. This form is available on the Human Resources website at <http://offices.depaul.edu/human-resources> or you may contact the Benefits Department to request a form.
- Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.

Mail the completed claim form and attached receipts to:

Prescription Drug Claims Payment Request
P.O. Box 20970
Lehigh Valley, PA 18002-0970

You must submit your claim to us within 36 months of the date you received the service, item, or drug. Claims not filed within 36 months of the date a service, item, or drug is received will not be eligible for payment.

When you receive care from your PCP or from another Provider who is affiliated with your Participating IPA/Participating Medical Group, or from your Woman's Principal Health Care Provider, you do not need to submit a claim for benefits, as long as you show your ID card to your Provider when you receive the services.

When you receive care from a Provider outside of your Participating IPA/Participating Medical Group (e.g. emergency care, medical supplies), usually all you have to do to receive your benefits is show your ID card to the Provider, and the Provider will typically submit any required claim information on your behalf. However, there may be situations when you will need to complete and submit claims on your own behalf.

To do so, send the following information to BCBS:

- An itemized bill from the Hospital, Physician or other Provider (including the Provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service, and the claim charge);
- The eligible person's name and ID number;
- The patient's name, age and sex; and
- Any additional relevant information.

Claims must be submitted 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

Claims must be filed no later than December 31st of the calendar year following the year in which the Covered Service was rendered. For the purposes of this filing time limit, Covered Services rendered in December will be considered to have been rendered in the next calendar year.

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 Over-65 Retiree Plan. 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 Over-65 Retiree Plan 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 determinations, 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 Over-65 Retiree Plan, 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 Over-65 Retiree Plan procedures and include all needed information, the 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 Over-65 Retiree Plan's 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 Over-65 Retiree Plan 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 Over-65 Retiree Plan, 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 Care Claims

If your claim for pre-service, post-service, urgent care or concurrent care is denied, the written explanation of the denial will:

- give the specific reason(s) for the denial and cite the applicable Over-65 Retiree Plan 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;
- include information that allows you to identify the claim involved (including the date of service, the health care provider, and 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);
- 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);
- 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);
- describe the Over-65 Retiree Plan's internal appeal procedures and external review process, including the applicable time limits and how to initiate an internal appeal or external review;
- for urgent care claims, describe the expedited review process applicable to such claims; 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.

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

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.

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, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

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***), 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 Over-65 Retiree Plan, 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.

Appeals Procedures

The review of the claim denial 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 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 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 Over-65 Retiree Plan in connection with the denied benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

If new or additional evidence is considered, relied upon or generated as part of the appeal review, or if an appeal denial is based on a new or additional rationale than was used to deny your initial claim for benefits, you will be provided with this evidence 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.

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

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

Coverage under the Over-65 Retiree 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.

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.

Explanation of Denied Health Care Appeals

If your health care appeal is denied, the written explanation of the denial will:

- include information that allows you to identify the claim involved (including the date of service, the health care provider, and 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;
- state why the claim has been denied, citing applicable Over-65 Retiree Plan 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 Medicare HMO participant, 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);
- 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);
- 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);
- describe the Over-65 Retiree Plan's internal appeal procedures and external review process, including the applicable time limits and how to initiate an internal appeal or external review;
- explain your right to bring a civil action against the Over-65 Retiree Plan under ERISA Section 502(a) within one year of receipt of the denial; 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.

Coverage under the Over-65 Retiree 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 Appeals

If your Over-65 Retiree 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 Over-65 Retiree 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 Over-65 Retiree 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 Over-65 Retiree Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Over-65 Retiree 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 Over-65 Retiree 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 Over-65 Retiree 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 Over-65 Retiree Plan to ensure that the IRO's decision is not contrary to the terms of the Over-65 Retiree 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 Over-65 Retiree 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	30 days	15 days	72 hours
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 Appeals

If you want to appeal a claim denial, you should submit your appeal to the applicable claims administrator at the address indicated below:

Medicare HMO Option

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

RECEIVING YOUR BENEFITS – CLAIMS AND APPEALS PROCEDURES FOR THE MEDICARE ADVANTAGE OPTION

If you are enrolled in the Medicare Advantage option and you receive services from a provider that accepts Medicare, in most cases you will not be billed directly. However, there may be situations in which you need to pay the full cost of medical care or a prescription drug right away.

Submitting Claims

If you need to complete and submit a claim form, the necessary forms are available at <http://www.bcbsil.com>, or you may call the toll-free number on the back of your ID card to request a claim form. Claims must be submitted to:

BCBS MAPD
Medical Claims Payment Request
P.O. Box 4195
Scranton, PA 18505

For **International Emergency/Urgent care claims**, mail your request together with any bills or receipts to us at this address:

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126

You must submit your claim to us within 12 months of the date you received the service, item, or drug. Claims not filed within 12 months of the date a service, item, or drug is received will not be eligible for payment.

Submitting Appeals

If you want to appeal a claim denial, you should submit your appeal to the applicable claims administrator at the address indicated below:

BCBS MAPD Plan
Appeals & Grievances
P.O. Box 4288
Scranton, PA 18505

If Medicare Advantage makes a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking BCBS to review and change a coverage decision they have made. Consult your Evidence of Coverage handbook for more detailed information.

Level 1 Appeal - When you appeal a decision for the first time. In this appeal, BCBS reviews the coverage decision BCBS made to check to see if they were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When they have completed the review they give you their decision.

Level 2 Appeal - If they say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. This Appeal Level is conducted by an Independent Review Organization (IRO) that is not connected to BCBS. (In some situations, your case will be automatically sent to the IRO for a Level 2 Appeal. If this happens, BCBS will let you know. In other situations, you will need to ask for a Level 2 Appeal.)

Level 3 Appeal - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the claim you are requesting must meet a minimum amount. If the dollar value of the claim is too low, you cannot make

another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process. This level is handled by an Administrative Law Judge.

More information about how claims and appeals are processed can be found in your Evidence of Coverage handbook.

Exhaustion of Administrative Remedies

These claims and appeals processes are provided in the hope that most disputes can be resolved. You or your covered spouse must follow and exhaust all the internal administrative remedies described above prior to bringing an action for benefits under the Over-65 Retiree Plan under Section 502(a) of ERISA.

Limitations on Actions

No legal action may be brought to recover under the Over-65 Retiree 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.

THIRD PARTY LIABILITY

This provision modifies any coverage under the Over-65 Retiree Plan.

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 Over-65 Retiree Plan.

However, the Plan 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 Plan from any recovery to the extent of benefits the Plan 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 Plan 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 Plan, 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 Plan, 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 Plan, and the Plan's interest therein shall be protected to the same extent as if such proceeds or assets were held in trust for the benefit of the Plan, to the extent of the amount paid by the Plans and subject to reimbursement to the Plan. By accepting benefits under the Plan, you agree that any amounts

you recover from a third party are assets of the Plan (up to the amount of benefits provided by the Plan on your behalf), that you will be a fiduciary of the Plan with respect to those amounts, and that you will be responsible for repaying to the Plan any costs and fees (including reasonable attorney fees) that the Plan 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 Plan's interest in such assets.

If you do not repay the Plan 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 Plan after payments by or for the responsible person are made.

Subrogation of the Plan

In addition to the Over-65 Retiree Plan's right to reimbursement, if the Plan pays benefits to you or a covered family member for a sickness or injury that another party is responsible for paying, the Plan will be subrogated to the amount of benefits it paid. This means that the Plan takes 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 Plan your right of payment from an insurer or other responsible party, but only up to the amount that the Plan paid for the claim. If a covered family member is a minor, the Plan may require that a court appoint a legal representative to act on behalf of the minor.

The Plan 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 Plan, 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 Plan's subrogation rights.

Subrogation and Reimbursement under the Medicare Advantage Option

In addition to the general subrogation and reimbursement provisions described above, if you are enrolled in the Medicare Advantage option you may have other responsibilities with respect to benefits under the Over-65 Retiree Plan. You should refer to your Evidence of Coverage handbook for more information.

ADMINISTRATIVE INFORMATION ABOUT THE OVER-65 RETIREE PLAN

Plan Administrator

DePaul, as the Plan Administrator, has the sole and complete discretionary authority to determine eligibility for Over-65 Retiree Plan benefits and to construe the terms of the Over-65 Retiree Plan and the Plan, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Over-65 Retiree Plan. Benefits under the Over-65 Retiree Plan 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 Over-65 Retiree Plan.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Over-65 Retiree Plan and the Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Over-65 Retiree Plan 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 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 Over-65 Retiree Plan. Any payments so made will be a full and complete discharge of any liability for such payment under the Over-65 Retiree Plan.

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 Over-65 Retiree Plan are not in any way subject to your or your spouse's debts and may not be voluntarily sold, transferred, alienated or assigned.

Recovery of Benefits

If you or a covered spouse receives a benefit payment under the Over-65 Retiree Plan 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 Over-65 Retiree Plan to or for the benefit of you or your covered spouse.

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 Over-65 Retiree Plan. If you make a fraudulent misstatement or omission of fact in an enrollment form or a claim for benefits under the Over-65 Retiree Plan, it may be used to deny claims for benefits under the Over-65 Retiree Plan.

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 Over-65 Retiree Plan.

Governing Law

The Over-65 Retiree Plan 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 Over-65 Retiree Plan shall be applied as if the illegal or invalid provision had never been a part of the Over-65 Retiree Plan.

STATEMENT OF YOUR RIGHTS UNDER FEDERAL LAW

As a participant in the Over-65 Retiree Plan, 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 Over-65 Retiree Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed 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 Over-65 Retiree Plan, 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 Over-65 Retiree Plan's 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 your covered spouse if there is a loss of coverage under the Over-65 Retiree Plan as a result of a qualifying event. Your spouse may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Over-65 Retiree Plan on the rules governing COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Over-65 Retiree Plan participants, ERISA imposes duties upon people who are responsible for the operation of the Over-65 Retiree Plan. The people who operate the Over-65 Retiree Plan, called plan fiduciaries, 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 a copy of Plan documents or the latest annual report from the Over-65 Retiree Plan 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 Over-65 Retiree Plan's 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 Over-65 Retiree Plan 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 Over-65 Retiree Plan, 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 the DePaul University Medical Plan for Retirees Age 65 and Over, which is offered under the DePaul University Health and Welfare Benefits Plan.
Employer Identification Number	36-2167048
Plan Number	The Over-65 Retiree Plan is part of the DePaul University Health and Welfare Benefits Plan, and the plan number is 520.
Type of Plan	Group health plan
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 Medicare Advantage option is a fully insured benefit option. The Medicare HMO option is a fully insured benefit option.
Type of Administration	Insurer administration
Address for Plan Administrator	DePaul University (or its delegate) Office of Human Resources 1 East Jackson Boulevard Chicago, IL 60604-2287 312-362-8232
Medicare Advantage Option Address for Claim Administrator	Blue Cross Medicare Advantage c/o Member Services P.O. Box 3686 Scranton, PA 18505 877-299-1008
Medicare HMO Option Address for Insurer/Claim Administrator	Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, Illinois 60680-4112 800-892-2803
Address for Service of Legal Process	Jose Padilla Vice President and General Counsel De Paul University 55 East Jackson Boulevard, 22 nd 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, 22 nd Floor Chicago, IL 60604-2287

**Address for Submitting Participant
Contributions for Coverage**

Medicare Advantage Option:

You will be billed separately by BCBS.

BCBS Medicare Advantage

PO Box 258822

Oklahoma City, OK 73125-8822

Medicare HMO Option:

Payments must be mailed to DePaul University

Human Resources

1 E Jackson Blvd

Chicago, IL 60604

The sections of this document, called the Summary Plan Description (SPD), summarize the Over-65 Retiree Plan in easy-to-understand language. The complete provisions of the Over-65 Retiree Plan 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 Over-65 Retiree Plan in effect as of October 1, 2017.

While DePaul expects to continue the Over-65 Retiree Plan indefinitely, it reserves the right to terminate, suspend, withdraw, amend or modify all or any part of the Over-65 Retiree Plan or the Plan, at any time, by written action of DePaul or its duly authorized delegate. Any such change or termination of the Over-65 Retiree Plan or the Plan will be based solely on the decision of the Plan Sponsor and may apply to any or all groups of retirees – including current or future retirees and their dependents – as determined under the Over-65 Retiree Plan. 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.