



**Health Benefits Plans
(Medical, Dental, and Vision)
Summary Plan Description**

General Information Section

(Effective: January 1, 2010)

The Health Plan Summary Plan Description (SPD) includes three major sections covering the active employee Medical Plan, the Dental Plan and the Vision Plan:

I. The **General Information** section ([THIS DOCUMENT](#)) contains the following information:

- [Joining the Health Plans](#)
- [Who is covered](#)
- [When coverage begins](#)
- [Changing your coverage](#)
- [How the Plan works](#)
- [Events that effect your coverage](#)
- [Receiving your benefits](#)
- [When coverage ends](#)
- [Continuing your coverage after you leave the University](#)
- [Converting to an individual policy](#)

II. The **Administrative Facts** section of this Summary Plan Description contains:

- Administrative information about the Plan
- Claims review
- HIPAA privacy rules
- How to appeal if your claim is denied
- Statement of your rights under federal law (including ERISA)
- Information about insurance certificates

III. **Program Information** Sections (separate documents for medical, dental, and vision)

Plans Covered by this Summary Plan Description (SPD):

- DePaul University Medical Program
- DePaul University Dental Program
- DePaul University Vision Program

Plans Described in Stand-alone SPDs:

- DePaul University Retiree Medical Plan
- DePaul University Group Life Insurance Program
- DePaul University Group Disability Coverage Program
- DePaul University Flexible Spending Account Program

For the Health Plans, as well as all the Health and Welfare Benefits, a "plan year" is January 1 to December 31. This summary describes the Health Plans in effect as of January 1, 2010.

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GENERAL INFORMATION

Covered Employee Classifications – All Plans (for reference purposes, describes eligible classifications for all of the Health Plans)

To be eligible for coverage under the Health Plans, you must be in one of the following employment classifications:

Full-Time Employee Classification – You are eligible to participate in all Medical Program options (the Traditional Plan is closed to new enrollees); the Dental Program; the Vision Program; the Group Life Insurance Program; the Group Disability Coverage Program; and the Flexible Spending Account Program on the date all of the following apply:

- you are in an active faculty or staff member position classified as full-time;
- you are in a faculty position, under a contract or letter of appointment issued by the Office of the Executive Vice President for Academic Affairs, or you are in a staff or security position classified as full-time and regularly scheduled to work at least 1,820 hours per year;
- you are **not** covered by a collective bargaining agreement;
- you are **not** in a position classified as a student employee; and
- you are **not** a member of the Midwest Province of the Congregation of the Mission (except for Group Disability Coverage)

Part-Time Employee Classification – Part-time employees are eligible to participate in the HMO option; the Dental Program; the Group Life Insurance Program (Basic Life only); and the Flexible Spending Account Program. Employees in positions classified as part-time are not eligible for the part-time benefits unless they meet the following criteria:

- **Faculty** – Benefits eligibility is reviewed at the end of each academic year to determine eligibility for the following academic year. In order to be eligible in the following academic year:
 - You must have at least one year of continuous service (determined by academic year, September through June) and you must have taught at least six 4-credit hour courses (or the equivalent as determined by the Deans and approved by the Executive Vice President for Academic Affairs) in that academic year (or seven courses including summer sessions); and
 - You must be committed to teach at least six 4-credit hour courses (or the equivalent) in that academic year (or seven courses including summer sessions) for the upcoming academic year (the year for which eligibility is being determined).
- **Staff** – Benefits eligibility is reviewed at the end of each calendar year to determine eligibility for the following calendar year. In order to be eligible in the following calendar year:
 - You must have worked one complete calendar year (January through December) and you must have completed 1,000 hours in that calendar year based on payroll records; and
 - Your department manager must certify that you are projected to work at least 1,000 hours in the following calendar year (the year for which eligibility is being determined).

In determining the 1,000 hours under the first requirement, all part-time positions held by an incumbent will be considered. Even if the total of all part-time positions meet or exceed 1,820 hours in a calendar year, the incumbent will still only be eligible for the part-time benefits.

Instructional Associate Classification – You are eligible to participate in all Medical Program options (the Traditional Plan is closed to new enrollees); the Dental Program; the Vision Program; the Group Life Insurance Program; the Group Disability Coverage Program; and the Flexible Spending Account Program if you are in a part-time faculty position classified as Instructional Associate. The Instructional Associate classification is a grandfathered group and is not available for new positions.

Retiree Classification – Pre-65 retirees are eligible to participate in all Medical Program options except the Consumer Driven Health Plan (the Traditional Plan is closed to new enrollees), and post-65 retirees

are eligible to participate in the Medicare Carve-Out Plan; the HMO Illinois Retiree Plan; and the Medicare Supplement (closed to new participants) options if you are a retired employee who had medical coverage at the time of retirement and you are:

- age 55 or older with 20 or more years of cumulative full-time service at the time of retirement, or
- age 62 or older with 10 or more years of cumulative full-time service at the time of retirement.

Voluntary Reduced Work-time Arrangement and Job Share Arrangements – You are eligible to participate in all Medical Program options (the Traditional Plan is closed to new enrollees); the Dental Program; the Vision Program; the Group Life Insurance Program; the Group Disability Coverage Program; and the Flexible Spending Account Program.

Vincentian House Employee Classification – If you are in a Vincentian House position, you are eligible to participate in all Medical Program options (the Traditional Plan is closed to new enrollees); the Dental Program; the Vision Program; the Group Life Insurance Program; and the Group Disability Coverage Program.

Independent contractors are not employees of the University and are not eligible for group benefits. Local and third country nationals (non-resident aliens) are not eligible for benefits.

Spouse, Second Domiciled Adult, and Dependent Coverage for the Health Plans

Spouses of Eligible Employees – A spouse is a person of the opposite sex to whom you are legally married (including legal separation) under federal law.

Children of Eligible Employees – To be eligible for medical coverage as a child dependent of a covered employee under the DePaul University Health Plans, the child must:

- be the unmarried natural born, adopted or placed for adoption (meaning placed permanently with the employee for adoption) child, stepchild, or a child for whom the employee is the court-appointed legal guardian
- under age 26, or under age 30 if a military veteran residing in Illinois

To be eligible for dental and vision coverage as a child dependent of a covered employee under the DePaul University Health Plans, the child must meet BOTH the **General Requirements** and the **Criteria for Tax-favored Health Benefits under the Internal Revenue Code**, below.

General Requirements

All of the following requirements must be met:

- Unmarried;
- Under the age of 23 (coverage continues to the end of the month in which age 23 is reached);
- Employee's natural born, adopted or placed for adoption (meaning placed permanently with the employee for adoption) child, stepchild, or a child for whom the employee is the court-appointed legal guardian*, or the employee's disabled child (refer to **Disabled Children** in this section) of any age; and
- Meet the criteria for tax-favored health benefits under the Internal Revenue Code (IRC).

Criteria for Tax-favored Health Benefits under the Internal Revenue Code

A child qualifies for tax-favored benefits by meeting one of the following of criteria:

- **Qualifying Child:** To be a qualifying child, a child must be under age 19, or under age 24 in the case of a full-time student, on the last day of the tax year, not provide over one-half of his or her own support, and have the same principal place of residence as the employee for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
- **Qualifying Relative:** To be a qualifying relative, a child must receive more than one-half of his or her support from the employee, and must not be anyone else's "qualifying child" dependent.

- *Child of Divorced or Separated Parents:* A qualifying child (as defined above) of divorced or separated parents who receives more than one-half of his or her support from the employee and the other parent.
- *Disabled Child:* A child of any age who is permanently and totally disabled (as defined under IRC section 22(e)3), who resides with the employee for more than one-half of the year, and who does not provide more than one-half of their own support. Alternatively, the permanently and totally disabled child could receive more than one-half of his or her support from the employee and still qualify for tax-favored benefits.

*Foster children, children placed temporarily for adoption, and grandchildren are not eligible for coverage unless the employee is their legal guardian and they meet all the other criteria detailed above as well.

Exceptions: Other Children of Employees Eligible for Health Plan Coverage

1. Children Covered Under a Qualified Medical Child Support Order (QMCSO):

Children for whom the employee is responsible to provide health coverage based on a qualified medical child support order (QMCSO) who meet the eligibility criteria specified in 1 through 3 in the **General Requirements** above, are eligible for coverage even if they do not meet the criteria for tax-favored health benefits under the Internal Revenue Code (IRC). **Important:** Children covered under a QMCSO who do not meet the criteria for tax-favored health benefits under the IRC will result in imputed income to the employee. In addition, employee contributions made on their behalf must be paid on an after-tax basis. Employees must inform Human Resources if their children do not meet the criteria in order to be taxed properly for this benefit.

2. Disabled Children:

A disabled child covered under the Plan can continue to be covered beyond the age when his/her coverage would normally end provided the disability began before the dependent reached the maximum age and your own coverage continues under the Plan and he/she:

- is deemed permanently and totally disabled;
- resides with you for more than one-half of the year; and
- is unmarried and primarily dependent on you for support.

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

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

If you are a new hire, and you had covered a disabled dependent who is beyond the regular limiting age of the Plan under your previous group health coverage, you may be able to cover your dependent under the DePaul Plan subject to providing proof of previous coverage and disability as your dependent in a group health plan prior to employment at the university.

Second Domiciled Adults (SDAs) of Eligible Employees – DePaul University extends certain benefits to Second Domiciled Adults (SDA) of active employees in lieu of a spouse.

Eligible Plans – The following DePaul University Benefits Plan Programs and options are available to eligible Second Domiciled Adults (SDAs) and eligible SDA children:

- Active Employee Medical Program (with the exception of the Consumer Driven Health Plan);
- Dental Program;
- Vision Program;
- Optional Dependent Life Insurance;
- Continuation of Coverage similar to COBRA on a limited basis;

- Retiree Medical on a limited basis; and
- Flexible Spending Account Program, as permitted.

Non-eligible Plans – The following benefits and programs are not available to SDAs or their children:

- Consumer Driven Health Plan option;
- Tuition Waiver Plan;
- Any Plan not listed in the immediately preceding section.

Coverage Categories – SDAs fall under one of two classifications: Related SDAs and Unrelated SDAs.

A related SDA is an adult member of the employee's household who meets all of the following criteria:

- Is the employee's relative including parent, son, daughter, grandchild, great grandchild, grandparent, great grandparent, brother, sister, half-brother, half-sister, uncle, aunt, nephew, niece, mother-in-law, father-in-law, step-parent, step-children;
- Is at least 18 years of age prior to the effective date of the coverage;
- Has shared the employee's principal residence at least 6 months prior to the effective date of the coverage;
- Does not have other group health insurance;
- Is not eligible for Medicare or Medicaid; and
- Meets the criteria for tax-favored health benefits under the Internal Revenue Code.

An unrelated SDA is an adult of the same or opposite sex of the employee who meets all of the following criteria:

- Is not related to the employee 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 the employee's principal residence at least 6 months prior to the effective date of the coverage;
- Has a close personal relationship with the employee (not a casual roommate or tenant) that is intended to be permanent;
- Shares with the employee a mutual obligation of support and responsibility for each other's welfare;
- Does not have other group health insurance; and
- Is not eligible for Medicare or Medicaid.

If an employee drops coverage for an unrelated SDA because the relationship ends or the SDA dies, the employee must wait 6 months before enrolling a different unrelated SDA.

Eligible Children of Second Domiciled Adults

To be eligible for coverage as a child of a covered employee's Second Domiciled Adult (SDA) under the Medical, Dental, Vision, or Optional Dependent Life Insurance Programs, the SDA's child must meet all of the following requirements:

- Is unmarried;
- Is under age 26 (under age 23 for dental and vision);
- Is the SDA's natural born, adopted or placed for adoption (meaning placed permanently with the SDA for adoption) child, stepchild, or a child for whom the SDA is the court-appointed legal guardian*, or the SDA's disabled child (refer to **Disabled Children** in this section) of any age;
- Has the same principal place of residence as the employee for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence); and
- Receives more than one-half of his or her support from the SDA or the employee.

Note: Children of an SDA can only be covered if the SDA is covered under the Plan.

**Foster children, children placed temporarily for adoption, and grandchildren are not eligible for coverage unless the SDA is their legal guardian and they meet all the other criteria detailed above as well.*

Additional Taxation of Benefits

Under federal law, enrolling a child dependent, an unrelated SDA or children of an SDA who do not meet the criteria for tax-favored health benefits under the Internal Revenue Code will result in imputed (taxable) income to the employee. In addition, employee premium contributions made on their behalf must be paid on an after-tax basis.

A dependent child qualifies for tax-favored benefits by meeting one of the following of criteria:

- *Qualifying Child:* To be a qualifying child, a child must be under age 19, or under age 24 in the case of a full-time student, on the last day of the tax year, not provide over one-half of his or her own support, and have the same principal place of residence as the employee for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
- *Qualifying Relative:* To be a qualifying relative, a child must receive more than one-half of his or her support from the employee, and must not be anyone else's "qualifying child" dependent.
- *Child of Divorced or Separated Parents:* A qualifying child (as defined above) of divorced or separated parents who receives more than one-half of his or her support from the employee and the other parent.
- *Disabled Child:* A child of any age who is permanently and totally disabled (as defined under IRC section 22(e)3), who resides with the employee for more than one-half of the year, and who does not provide more than one-half of their own support. Alternatively, the permanently and totally disabled child could receive more than one-half of his or her support from the employee and still qualify for tax-favored benefits.

An Unrelated SDA is eligible for tax-favored health coverage only if all the following requirements are met:

- He or she lives with the employee (shares a principal residence) for the full tax year, except for temporary reasons such as vacation, military service, or education;
- He or she is a citizen or legal resident of the United States;
- He or she isn't anyone's section 152 qualifying child dependent; and
- He or she receives more than half of his or her support from the employee.

A child of an SDA qualifies for tax-favored benefits by meeting one of the following criteria:

- *Qualifying Child:* To be a qualifying child, a child must be under age 19 or under age 24, in the case of a full-time student on the last day of the tax year, not provide over one-half of his or her own support, and have the same principal place of residence as the employee for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
- *Qualifying Relative:* To be a qualifying relative, a child must receive more than one-half of his or her support from the employee, and must not be anyone else's "qualifying child" dependent, including the SDA's qualifying child.
- *Child of Divorced or Separated Parents:* A qualifying child (as defined above) of divorced or separated parents who receive more than one-half of their support from the employee and the other parent.
- *Disabled Child:* A child of any age who is permanently and totally disabled (as defined under IRC section 22(e)3), who reside with the employee for more than one-half of the year, and who does not provide more than one-half of their own support. Alternatively, the permanently and totally disabled child could receive more than one-half of his or her support from the employee and still qualify for tax-favored benefits.

DePaul will comply with the federal tax rules as follows:

- Coverage for a non-tax favored child dependent will automatically be on a taxable basis unless the employee returns a completed Declaration of Tax Status Form to HR;
- Coverage for a related SDA will automatically be on a tax-favored basis. Employees may make pre-tax contributions for the coverage of the related SDA and will not have imputed income;
- Coverage for an Unrelated SDA and children of all SDAs will automatically be on a taxable basis unless the employee returns a completed Declaration of Tax Status form to HR; and

- Tax status changes will be made on a prospective basis only.

For non-tax favored child dependents, SDAs and children who are not eligible for tax-favored health coverage, DePaul will:

- Establish the fair market value of the health coverage;
- Include this amount (less any after-tax employee contributions) in the employee's income when determining income and payroll taxes;
- Report the imputed income on the employee's W-2; and
- Deduct employee premium contributions for the non-tax favored child dependent, unrelated SDA and/or SDA's children on an after-tax basis.

Important Note Regarding Ineligible Dependents

If an employee covers an ineligible child, the employee will be responsible for reimbursing claims paid by the Plan on behalf of the child for the time the child was not an eligible dependent. Further, the employee may be subject to back taxes and IRS penalties. **Employees are strongly advised to seek the advice of tax counsel if there are any questions at all related to the tax status of a dependent.**

Joining the Health Plans

Full-Time Faculty and Staff, Spouses and Children

When you are newly eligible to enroll in the Health Plans, you must enroll online through Campus Connection within 31 days of your date of hire if you are a full-time staff member. If you are a new faculty member starting in the fall, you must enroll within 31 days of September 1st.

If you are a full-time staff member, your chosen coverage will be effective on the 1st of the month following your date of hire (or on the actual date of hire if you are hired on the 1st of the month) provided you enroll correctly. Coverage for new faculty members starting in the fall will be effective on September 1st. Your paycheck deductions generally will begin on your first paycheck after you have completed your enrollment online.

If you are a full-time faculty member and your job begins during the academic year already in progress, then your time limit for enrolling in benefits and your coverage effective date will be that same as for full-time staff.

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

During your initial enrollment period, if you do not enroll online through Campus Connection within your specified time limit based on your employee classification, you will have the following coverage for the rest of the year, and pre-tax deductions for your medical coverage will be taken from your paychecks:

- Employee only Blue Cross Blue Shield PPO medical coverage;
- Basic term life insurance equal to 1.5 times individual annual benefit base salary up to a maximum coverage amount of \$300,000; and
- Group disability coverage.

If you do not wish to enroll in a medical option offered by the University, you must elect the "Waive" option during your initial enrollment period (you will be required to provide proof of other medical coverage if you choose to waive the DePaul's medical coverage). If you waive coverage, you will receive additional taxable compensation of \$30 per month (full-time employees only).

Before you can enroll a spouse and/or dependent children on your health coverage, you must complete and submit a *Dependent Add/Change* form. If you are enrolling dependent children age 19 or over, you

must also complete a *Declaration of Tax Status* form. Forms are available on the Human Resources website or may be obtained from the Benefits Department

After the initial enrollment period, you will be able to change your coverage during the year only if you have an eligible status change or experience another event under which election changes are allowed. Refer to ***Changing Your Coverage***.

During the annual enrollment period in the fall, you will have the opportunity to re-enroll in the Health Plans for the next calendar year. Your new coverage will start on January 1. Enrollment instructions, a notice of the enrollment period and annual enrollment deadline will be sent to each eligible employee. **If you do not re-enroll through Campus Connection, you will have the same benefits that you chose the year before.** There are exceptions to this rule: if you had a **Health Savings Account**, a **Health Care Flexible Spending Account**, or a **Dependent Care Flexible Spending Account**, your elections will not carry over, and you must re-enroll each year. Changes will not be allowed after the annual enrollment deadline.

Part-Time Faculty and Staff, Spouses and Children

Part-time employees will be notified of their eligibility to participate in benefits once they are deemed as meeting the **Part-Time Employee Classification** detailed in the ***Covered Employee Classifications*** section. Part-time faculty will be notified in the summer for coverage effective on September 1st, and part-time staff will be notified in the fall for coverage effective on January 1st.

Part-time employees will have 31 days from the date of their notification to enroll in benefits. If you do not enroll within 31 days of your notification, your coverage under the Medical Program will be waived and you will have Basic Group Life Insurance only. If you are part-time staff, your next opportunity to enroll will be the following year provided you are still deemed as meeting the **Part-Time Employee Classification** requirements. If you are part-time faculty, your next opportunity to enroll will be during the next annual enrollment period.

Continued benefits eligibility for part-time employees is dependent upon continuing to meet the **Part-Time Employee Classification** requirements.

Second Domiciled Adults and Children of SDAs

When coverage may be elected:

An employee may elect coverage for an SDA only during open enrollment or within 31 days of one of the following events:

- The employee and SDA first become eligible (i.e., first meet all the eligibility criteria);
- The employee and unrelated SDA meet the 6 month cohabitation requirement;
- The Second Domiciled Adult loses other group coverage due to change in employment, work site or income; or
- The employee meets the 6 month waiting period for enrolling a new Unrelated SDA after having previously dropped coverage for an Unrelated SDA due to death or termination of the relationship.

Before you enroll an SDA:

Before you (the employee) enroll an SDA, you must first enroll yourself and any of your eligible children in the medical plan using the on-line enrollment application. Then you can download the *Second Domiciled Adult Affidavit of Eligibility* and the *Declaration of Tax Status* forms from the HR website to enroll your SDA and your SDA's children, if any.

Required Documentation:

To enroll an SDA, an employee must complete and return a **Second Domiciled Adult Affidavit of Eligibility** and required documentation within 31 days of electing coverage. Employees who fail to

provide the required documents will not be allowed to enroll a SDA until the next annual enrollment period, except as noted above. Employees only need to complete the forms once, at initial enrollment.

In addition, employees who enroll an Unrelated SDA may choose to complete a **Declaration of Tax Status**, if applicable. The **Declaration of Tax Status** is used by an employee to certify that an Unrelated SDA or child(ren) of an SDA is eligible for tax-favored status. If the SDA's tax status changes, the employee may file a new **Declaration of Tax Status**. Tax status changes will be made on a prospective basis only. Forms are available on the Human Resources website or may be obtained from the Benefits Department.

When Coverage Begins

Your coverage begins on the first day of the month following the date you become eligible provided you elect coverage. If you begin employment on the first day of the calendar month, then your coverage will begin on the same day provided you elect coverage. If you elect to cover eligible dependents, coverage for your dependents begins the same day as your coverage.

You must enroll during the first 31 days after you become eligible. For full-time employees, if you fail to enroll within this 31 day limit, you will be defaulted into the Blue Cross Blue Shield PPO medical option with single coverage. If you are a part-time employee and you fail to enroll within the 31 day limit, your medical coverage will be waived.

If defaulted, you can enroll in other options and make changes to your medical coverage during the next annual benefits enrollment period, for coverage that becomes effective January 1 of the following year. Part-time staff does not have an annual enrollment period.

Once you elect coverage, you cannot change your coverage during the year unless you have a qualifying change in family status or coverage change.

Changing Your Coverage

Full-time and Part-time Faculty, Staff, Spouses and Children

Under the provisions of the Health Insurance Portability and Accountability Act (HIPAA), special election provisions, changes may be made to certain elections within 31 days corresponding to special qualifying events.

As a general rule, the benefit options and coverage categories you choose are effective until December 31 of the year for which you made them. However, there are three situations under which you will be able to change your coverage choices during the year:

- If you have a qualified change in status (refer to **Change in Status** as follows);
- If you experience another event, such as a change in your spouse's plan, under which other election changes are allowed (refer to **Other Election Changes** as follows); or
- If you had not enrolled yourself or your dependents due to other medical coverage but lose that other coverage (refer to **Loss of Other Medical Coverage** as follows).

To make changes, contact the Benefits Department for a Flexible Benefits Enrollment - Family Status Change form to complete and return. You may be asked to provide documentation related to your change in status. Changes become effective as of the date of the change in status. If you do not implement a change in status within 31 days of your change in status or other event, you will **not** be allowed to change your coverage until the next annual enrollment.

Change in Status

If you have a qualified change in status, you may change your benefit options and coverage categories within 31 days of the event. Your changes in coverage must be consistent with the change in status.

The rule is that the benefits coverage change must be on account of and correspond with a change in status that affects your or your dependent's **eligibility for coverage** under the Health Plans or another employer's plan, including a change in status that results in an increase or decrease in the number of your dependents who may benefit from the coverage.

The Benefits Department will review the situation to determine if a qualifying change in status has occurred and if the requested election change is consistent with the change in status. If approved, the change of coverage will be effective on the date of the change of status. Any change in your deductions (if applicable) will be effective the first pay period following the change.

The following are considered changes in status:

- you get married, divorced or legally separated, or your marriage is annulled;
- you have, adopt or gain legal guardianship of a child, or a child is placed with you for adoption;
- your spouse or dependent child dies;
- your spouse or dependent child ends or begins coverage;
- you, your spouse or a dependent child takes or returns from an unpaid leave of absence; changes his or her worksite; is involved in a strike or lockout; or experiences any other employment status change affecting eligibility for coverage under a plan;
- you, your spouse or a dependent child changes his or her place of residence affecting eligibility for coverage under a plan;
- your last remaining dependent child no longer qualifies as a dependent; or
- your dependent child regains eligibility as a dependent.

Special Rules for Newly Eligible Dependents

If you acquire a newly eligible dependent, a special enrollment rule applies in addition to the change in status rules. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you will be able to enroll yourself (if not previously covered) and your dependents in the Medical Program, provided that you request enrollment within 31 days after the marriage, birth, adoption, or permanent placement for adoption.

If you do not add your newly eligible dependent or change your coverage within 31 days of your change in status or other event, you will **not** be allowed to change your coverage until the next annual enrollment.

Other Election Changes

You may also make mid-year corresponding election changes to your benefit options and coverage categories within 31 days of the following events:

- the University coverage is significantly reduced or ends. Note that 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 all together. 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;*
- there is a significant cost increase in a benefit option, in which case you can 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. You will not, however, be allowed to change your Dependent Care Account coverage level on account of a significant cost increase where the dependent provider is your relative;*
- there is a significant cost decrease in a University benefit option, in which case you can select that option;*
- a similar benefit option is added, significantly improved or eliminated;*
- you, your spouse or a dependent child loses or gains Medicare or Medicaid entitlement;
- there are changes pursuant to a judgment, decree or court order, including a qualified medical child support order (QMCSO). Note, you may cancel coverage for a child pursuant to a judgment, decree, or order to enroll a child in another employer's plan only if the child is actually enrolled in the other plan; or

- there are significant changes under your spouse's plan due to a mid-year election change that satisfies the Internal Revenue Code Section 125 regulations or a change during an open enrollment period where your spouse's plan has a different plan year or enrollment period.*

* You will not be allowed to change your Health Care Flexible Spending Account participation on account of these events.

With respect to your Dependent Care Flexible Spending Account and the first four events above, you may, for example, adjust your account contribution if:

- you change your daycare provider;
- the number of hours of daycare changes; or
- your non-relative daycare provider significantly increases or decreases your cost for childcare.

Loss of Other Medical Coverage

If you had not enrolled yourself or your dependents in the Plan when first eligible to do so due to other health care coverage but lose that other coverage, you may be able to enroll in the Plan by implementing a status change through the Benefits Department within 31 days of the loss of other coverage. The Plan coverage will be effective as of the date the other coverage is lost. Special enrollment rules for loss of other coverage are summarized below:

- you did not enroll in the DePaul Plan because of other coverage and you have reached the maximum lifetime limit for benefits under your current plan;
- you did not enroll in the DePaul Plan because of other coverage and you or your spouse no longer live or work within the health insurance coverage area and have no access to other coverage;
- you did not enroll in the DePaul Plan because of other coverage and your dependent child has reached an age at which they no longer qualify as a dependent child under the Plan (but are under the age of 26);
- you did not enroll in the DePaul Plan because of other coverage and you lost the other coverage for yourself or your dependent(s) because you or your dependent(s) either stopped being eligible (but not for nonpayment of premiums or "for cause" such as fraudulent claims or intentional misrepresentation) or the current employer stopped contributing for that coverage; or
- If the other coverage you had at the time you did not enroll in the DePaul Plan was COBRA coverage, the COBRA coverage period has since been exhausted (i.e., the coverage continuation period of 18, 29, or 36 months, as applicable, must have been completed).

When Mid-Year Coverage Changes Become Effective

For special enrollments, coverage is retroactive to the date of the qualifying event provided such enrollment is allowed by the carrier and permissible under the applicable Plan provisions and provided the application for coverage is completed within the 31-day election period.

Second Domiciled Adults and Children of SDAs

When coverage may be elected:

An employee may elect coverage for a SDA only during open enrollment or within 31 days of one of the following events:

- The employee and SDA first become eligible (i.e., first meet all the eligibility criteria);
- The employee and unrelated SDA meet the 6 month cohabitation requirement;
- The Second Domiciled Adult loses other group coverage due to change in employment, work site or income; or
- The employee meets the 6 month waiting period for enrolling a new Unrelated SDA after having previously dropped coverage for an Unrelated SDA due to death or termination of the relationship.

How Benefit Plan Rates Are Determined

Each benefit option has an associated rate, which is the amount the benefit costs you. The rates for each benefit option are posted on the HR website. The University pays most of the cost of the before-tax benefits. Rates are based on these factors:

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

In most cases, rates will not change in the middle of a year, even if the cost of providing coverage changes. However, if the cost for coverage increases or decreases during the year, the Plan reserves the right to make a corresponding change to the rate for that coverage. Also, if there is a mid-year cost increase for any coverage excluding the Health Care Flexible Spending Account that is significant, you will be allowed to make a change to your coverage option for the rest of the year. Refer to the **Other Election Changes** section.

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

How the Plan Works

The University's Health Plans allow you to choose your own coverage under each benefit program from a variety of options. You begin by selecting your benefit option from each of the following programs:

- Medical Program
- Dental Program
- Vision Program

Then you select the dependents you wish to cover (if any) under the Health Plans. The number and types of dependents you choose to cover will determine your coverage category in each program. The coverage categories are:

- Single
- Single plus Spouse
- Single plus Children
- Family

Once you have made your choices, you will generally pay for them with pre-tax dollars. When you pay for a benefit using pre-tax dollars, this money automatically will be taken out of your paychecks before taxes are calculated. That means that you are not taxed on these amounts. Because pre-tax dollars are not subject to Social Security Taxes, your future Social Security benefits may be slightly reduced if your earnings are less than the Social Security wage base.

The noted exception is if you choose to cover a non-tax favored dependent child on your medical plan. The premiums for covering a non-tax favored dependent child are taken on a post-tax basis.

Employment Events and Affect on Coverage

In general, these are the rules that apply to changes in your coverage. However, each benefits program has its own rules, so it is important to read the individual benefit program sections to find out how each is affected by the following events.

If you have a "change in status," you will be able to change your coverage choices under the Health Plans. To learn about changes in status, refer to the **Changing Your Coverage** section.

If Your Salary Changes

Health benefits are unaffected by salary changes.

If You Are on a Leave of Absence

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

- Medical or disability leave
- Personal leave
- Faculty Research Leave
- FMLA Leave
- Military Leave

Employees on Paid Leave: Employees on a paid leave of absence will continue to have the premiums deducted from bi-weekly paychecks.

Employees on Unpaid Leave: Employees on an unpaid leave are responsible for paying the employee contribution amount for those benefits that require an employee contribution. This can be done on an after-tax basis by personal check and forwarding such payment to the Human Resources department; by arranging pre-payment via pre-tax (if appropriate) deductions prior to the leave; or by retroactive payment of premium on a pre-tax (if appropriate) basis after returning to active employment.

If You Die During Employment

If you die during your employment, your spouse and dependents will be eligible for COBRA coverage for 36 months. Your spouse is also eligible to continue your Health Care Flexible Spending Account under COBRA. Refer to the ***Continuing Your Coverage after You Leave the University*** section.

If you die during your employment and would have otherwise been eligible to retire and to enroll in the Health Plans for Retirees, then your surviving spouse and dependent child(ren) under the age of 26 will be eligible to enroll in the Retiree options. Refer to the ***When You Retire*** section.

If You Leave the University

If your employment with the University ends, your health coverage will end at the end of the month following your termination date. Refer to the ***Continuing Your Coverage after You Leave the University*** section to be informed of your continuation options.

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

If you are rehired beyond 31 days from your termination date or are rehired in a later calendar year, you will be treated as a new employee for the purposes of enrolling in the Health Plans. Refer to the ***When Coverage Begins*** section.

When You Retire

When you retire, you may be eligible to enroll in the University Medical Program for Retirees. You can find out more about Retiree coverage by referring to the Retiree Medical Plan SPD.

Second Domiciled Adults

An employee may drop coverage for a Second Domiciled Adult only during open enrollment or within 31 days of one of the following events:

- Eligibility ends;
- The SDA enrolls in other group coverage;
- The SDA becomes eligible for Medicare or Medicaid; or
- The SDA dies.

Employees must notify the Benefits Department within 31 days of such an event.

Receiving Your Benefits

To receive your benefits under the Health Plans, you or your provider need to file a claim. When a claim form is required, you can get the proper claim form online through the HR website.

There is a limit on the amount of time you have to file claims. For dental claims, you have until December 31 of the year following the date of service. For vision claims, you have 6 months to file from the time the service is incurred. The claim filing time limit for medical claims depends on the medical option you select. Refer to the **Medical Program Details** document for more information. If you file your claim after the deadline, it will not be considered an eligible expense and will not be paid. If you file a claim for benefits and it is denied, you may appeal your claim. Refer to the **How to Appeal if Your Claim Is Denied** section in the **Administrative Facts** document.

When Coverage Ends

Your Medical, Dental, Vision and Flexible Spending Account coverage will end on the last day of the month that any of the following situations occur:

- your employment with the University terminates for any reason;
- you lose eligibility for benefits under the Plan;
- the Plan is terminated;
- your group of employees is no longer eligible; or
- you stop making contributions needed to pay for your coverage.

Generally, your dependents' coverage will end on the day they no longer qualify as eligible dependents. However, if a dependent child loses eligibility status, their coverage will continue until the end of the month in which they lose their eligibility status.

You may be able to continue coverage at your own expense if coverage for you or your dependents ends. Similarly, covered dependents may independently be able to continue their coverage should they lose eligibility.

Refer to **Continuing Your Coverage After You Leave the University** and **Converting to an Individual Policy** in this section, or contact the Benefits Department to find out whether or not you can continue coverage.

If you change status without actually terminating employment (for example, a leave of absence), you should contact the Benefits Department for specifics regarding duration of your coverage.

Continuing Your Coverage After You Leave the University

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal law, you and your eligible dependents have a right to continue coverage at your own expense after you leave the University. COBRA rights do not extend to Second Domiciled Adults (SDAs). Certain continuation of coverage options are available to eligible SDAs and their children. Refer to **Continuation of SDA Coverage**.

COBRA gives you and your eligible dependents the right to continue coverage if your coverage ends for any of the following reasons:

- employment with the University ends for any reasons other than gross misconduct;
- your work hours are reduced, making you ineligible for coverage; or

- your leave of absence has expired under the Family Medical Leave Act of 1993 (but not earlier due to nonpayment of required premiums).

In addition to the reasons above, your dependents can continue coverage if they lose their coverage for any of the following reasons:

- your dependents are no longer eligible;
- you die;
- you and your spouse divorce, making your spouse ineligible for coverage, or
- you become entitled to Medicare benefits.

It will be your responsibility to initiate a change in status with the Benefits Department within 31 days of any loss of coverage due to divorce or a child's loss of eligible dependent status. If the change in status is not initiated within 31 days of the event, it is your responsibility to inform Benefits of any such loss of coverage. This notice must be given orally, electronically or in writing within 60 days of the event or your dependents lose COBRA rights. Notice also will be accepted from your dependent or from a representative acting on behalf of your dependent or you.

Programs to which COBRA Applies

COBRA applies to the Medical Program, Dental Program, Vision Program, and Health Care Flexible Spending Account Program.

The COBRA claims administrator will give you a written notice, advising you that you have a right to continue your coverage under COBRA. The notice will tell you how much the coverage will cost. If you are covered under COBRA, your cost is not guaranteed; you always will pay the current cost of the coverage.

If you want to continue coverage under COBRA, you must complete and return the election notice to the claims administrator within 60 days of the later of these two dates:

- the date the coverage would otherwise end; or
- the date of the written election notice.

Your first payment is due 45 days after your election and must cover the period of time back to the first day of your COBRA continuation coverage. Subsequent payments are due once a month. Payment coupons will be sent to you after you elect continued coverage.

If you qualify for coverage continuation under COBRA, you/your dependents may elect to continue the coverage you had at the time your regular coverage ends. At that time, you may not add a dependent not covered previously, nor may you change your medical or dental option. However, you can elect not to cover a dependent who was covered previously. To drop a dependent, you must properly complete and submit the election notice to the claims administrator within 60 days of the event that made you eligible for COBRA coverage. Future changes can be made during the next open enrollment period or if you have a change in status.

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

Length of COBRA Coverage

Your COBRA coverage will begin on the day after your regular coverage ends, provided you have paid the required premium. Your COBRA coverage will continue until the first of the following:

- 18 months from the date your regular coverage ends, if you are eligible for COBRA because you stop working for the University or because your work hours are reduced and you are no longer eligible for the University coverage;
- 29 months from the date your regular coverage ends, if you or a covered dependent were disabled (as defined by Social Security) at the time you qualified for COBRA coverage or become

disabled during the first 60 days of COBRA coverage because of termination or reduced hours (or within 60 days from the date of birth or adoption for a child born or adopted during the COBRA continuation period). This would also apply to any non-disabled family members of the disabled person who are entitled to COBRA coverage. The disabled person must give the Benefits Department written notice of the disability by submitting a copy of the Social Security determination within 60 days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced. The disabled person also must notify Benefits in writing within 30 days after a final determination under the United States Social Security Act that the person is no longer disabled, and coverage will end as of the first month that starts more than 30 days after the determination. Notice also will be accepted from you; another family member who is entitled to COBRA coverage; or any representative acting on behalf of the disabled person, a family member, or you;

- 36 months from the date your regular coverage ends, if your dependents are eligible for COBRA because you die, you first become entitled to Medicare after electing COBRA, you divorce, or because your dependent loses eligibility status;
- the person responsible for paying for the coverage does not make a payment by the due date;
- the person who is covered first becomes covered under another group health plan after electing COBRA (this is not a reason for your coverage to end if the new plan does not cover a pre-existing condition you have that is covered under your COBRA coverage). COBRA coverage will not end due to other group health plan coverage if, along with COBRA continuation coverage, you are entitled to continue coverage due to a qualified military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994;
- the person who is covered first becomes entitled to Medicare after electing COBRA (not applicable to Dental or Vision coverage); or
- all University health programs are terminated.

NOTE: The 18 or 29 months indicated in the first two bullets may be extended for affected individuals up to 36 months from the date regular coverage ends due to termination or reduction in hours of employment if other events (i.e., employee's death, divorce from the employee, employee's Medicare entitlement, or a dependent child ceasing to be eligible for coverage) occur during the original 18 month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made an individual eligible to elect continuation coverage. Written notice of such an event must be given in writing to the Benefits Department within 60 days after the event. Notice will be accepted from you; the affected individual or another family member who is entitled to COBRA coverage; or any representative acting on behalf of such person(s) or you.

If you continue your coverage under these provisions, the amount of time you can be covered under COBRA is reduced by any time you have taken as a temporary layoff, leave of absence, or military leave.

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.

The conversion privilege described in the ***Converting to an Individual Policy*** section will be offered within the 90-day period that ends on the expiration date of the maximum period of COBRA coverage (18, 29 or 36 months). However, no conversion will be provided if the individual does not actually maintain COBRA coverage for the full maximum period.

Continuation of SDA Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continuation of group health coverage for employees and their eligible dependents in certain situations. Although Second Domiciled Adults are not considered an eligible dependent under the COBRA law, DePaul will offer employees the option to continue medical coverage for Second Domiciled Adults under certain circumstances, or "qualifying events." This option is called "Continuation of Coverage".

An employee whose SDA loses coverage under any of the circumstances summarized in the chart below may elect Continuation of Coverage for the SDA in conjunction with the employee's electing COBRA for

his or her own coverage. The employee must pay the full cost of the SDAs coverage, plus the 2% administrative fee. Employees currently on COBRA may not elect coverage for an SDA or SDA's children.

Qualifying Event	Maximum Continuation Period for a Second Domiciled Adult
The employee loses coverage because of reduced work hours or takes unpaid leave other than under the Family Medical Leave Act	18 months
Employee's employment terminates for any reason except gross misconduct	18 months
The employee is disabled — as defined by the Social Security Act — at the time of a COBRA qualifying event or at any time during the first 60 days of COBRA or COBRA Coverage Equivalent	29 months

Only the employee may elect Continuation of Coverage for an SDA. Continuation of Coverage is not available to an SDA if loss of coverage is due to one of the following:

- The employee dies;
- The SDA's eligibility ends for any reason; or
- The employee becomes entitled to Medicare.

Continuation of coverage for an SDA or SDA's children ends when:

- The employee fails to pay the required premium;
- The employee terminates his or her own COBRA coverage; or
- The employee notifies DePaul that they wish to discontinue the SDA's coverage.

HMO Illinois Continuation of Coverage

If you participate in the fully insured HMO Illinois plan, then you also have special Illinois continuing coverage rights. Further, your spouse and dependents also have special continuation rights. Please see your HMO Illinois Insurance Certificate for details.

Converting to an Individual Policy

If your coverage ends, you may have the right to "convert" or change your Medical Program coverage into individual policies. Please contact the applicable insurance companies for additional details.

For HMO Illinois, in order to convert your coverage you should contact HMO Illinois to get an application and return the application to HMO Illinois within 31 days of the date that your coverage is terminated. You will then be covered by HMO Illinois on an individual "direct payment" basis. Your converted coverage will be effective from the date that your DePaul University 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 of this SPD. The converted coverage will provide, at minimum, benefits for basic health care services as defined in the HMO Act. HMO Illinois is not required to offer conversion coverage to you if you no longer live within the HMO Illinois service area. 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 if the University terminates its contract with HMO Illinois and replaces it with other coverage, or when your coverage has been terminated for:

- failure to pay a required premium or charge;

- fraud; or
- material misrepresentation in enrollment or in the use of services or facilities.

Certificates of Creditable Coverage

When your Medical Program coverage ends for any reason, you will be issued a certificate of creditable coverage by the administrator of your Medical Program option. Your dependents will also receive a certificate of creditable coverage if their coverage ends. This certificate verifies information about your DePaul University health coverage. It may be applied against any pre-existing condition exclusion period under another health care plan. You or your dependents may also request to receive a certificate of creditable coverage within 24 months after coverage ends.

You or your dependents will automatically receive a certificate of creditable coverage when:

- you or your dependents lose Medical Program coverage, whether or not you are entitled to elect COBRA continuation coverage; and
- you or your dependents lose COBRA continuation coverage, if you were entitled to and elected COBRA continuation coverage.

The sections of this document, called the Summary Plan Description (SPD), summarize the University Health Plans in easy-to-understand language. The complete provisions of the Plans are found in the official program documents, which rule in the case of any difference between them and this document.

This summary describes the Health Plans in effect as of January 1, 2010.

Participation in a Health Plan in no way guarantees employment with the University. While the University expects to continue the Health Plans indefinitely, it reserves the right to terminate, suspend, withdraw, amend or modify all or any part of the Plans, or to change the cost of coverage, at any time without notice. Any such change or termination of the Plans will be based solely on any decision of the Plan Sponsor and/or the Plan Administrator and may apply to any or all groups of employees – including active and disabled employees, and current or future retirees and their dependents – as determined under the Plans.

No supervisor, manager or other representative of the University 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.