DEPAUW UNIVERSITY
Est. 1837

c/o Amwins Group Benefits
50 Whitecap Drive
North Kingstown, RI 02852

DePauw University

Retiree Medical Program

Your 2023 Benefits

DEPAUW UNIVERSITY
Est. 1837

Your 2023 Retiree Medical Benefits

Having quality health insurance is of utmost importance. To provide the best insurance value available, factoring coverage, service and price, DePauw University offers the enclosed Retiree Medical Program and prescription drug plans.

This Post-65 Retiree Medical Program is available to you and your Medicare eligible spouse. To participate, you must be 65 or older and enrolled in Medicare Parts A & B.

This program offers a medical plan underwritten by Transamerica Life Insurance Company and serviced by Amwins Group Benefits, Inc.

This program includes three Medicare Part D prescription drug plan options underwritten by Express Scripts Insurance. To enroll in a prescription drug plan you must also elect the medical plan. By electing the prescription drug plan you will be enrolled in a Medicare Part D plan. If you are currently enrolled in a Medicare Part D plan, you will need to contact the administrator and end enrollment.

How to enroll

- Review the information in this booklet
- Complete and sign the appropriate enrollment form(s)
- Return the above items and first month's payment in the postage-paid return envelope

Materials must be received to activate your benefits.

If you have any questions, please contact the Amwins Group Benefits Customer Care Center toll-free at 1-888-883-3757, Monday through Friday, from 8 a.m. to 8 p.m. (EST).

Amwins Group Benefits Customer Care Center
Toll-Free 1-888-883-3757

Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: Transamerica Life Insurance Company

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

Services	Medicare Pays	Plan Pays	You Pay
HOSPITAL CONFINEMENT BENEFIT* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but Part A Deductible	Part A Deductible	**$0**
61st through 90th day	All but Part A Coinsurance	Part A Coinsurance	**$0**
91st through 150th day (While using 60 lifetime reserve days)	All but Part A Coinsurance	Part A Coinsurance	**$0**
Once Lifetime Reserve days are used:			
Additional 365 days:	$0	100% of Medicare Eligible Expenses	**$0**
Beyond the Additional 365 days	$0	$0	**All costs**
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but Part A Coinsurance	Part A Coinsurance	**$0**
101st day and after	$0	$0	**All costs**
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expense When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints	$0	3 pints	**$0**
Additional amounts	100%	$0	**$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	**Balance**

Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: Transamerica Life Insurance Company

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
OUT-PATIENT MEDICAL EXPENSES - - In or Out of the Hospital and Out-Patient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
Medicare Part B Deductible: First Medicare-approved amounts**	$0	$0	**Part B Deductible**
Next Medicare-approved amounts	Generally 80%	$0	**20% until Calendar year deductible is met ($400)**
Next Medicare-approved amounts	Generally 80%	16%	**4% until Out Of Pocket Maximum is met ($1,250)**
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**0%**
Part B Excess Charges (Above Medicare Approve Amounts)	$0	100%	**0%**
BLOOD			
First 3 pints	$0	All costs	**$0**
Next Medicare Approved Amounts**	$0	$0	**Part B Deductible**
Next Medicare-approved amounts	Generally 80%	$0	**20% until Calendar year deductible is met ($400)**
Next Medicare-approved amounts	Generally 80%	16%	**4% until Out Of Pocket Maximum is met ($1,250)**
Remainder of Medicare Approved Amounts	80%	20%	**$0**
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	**$0**

Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: Transamerica Life Insurance Company

MEDICARE PARTS A & B

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE – Medicare Approved Services:			
Medically necessary skilled care services and medical supplies	100%	$0	**$0**
DURABLE MEDICAL EQUIPMENT			
First of Medicare Approved Amounts**	$0	$0	**Part B Deductible**
Next Medicare-approved amounts	Generally 80%	$0	**20% until Calendar year deductible is met ($400)**
Next Medicare-approved amounts	Generally 80%	16%	**4% until Out Of Pocket Maximum is met ($1,250)**
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	**$250**
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime max

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**Once you have been billed the first dollars of Medicare-Approved amounts for covered services (which are noted with two asterisks), your Medicare Part B Deductible will have been met for the calendar year.

Benefits are paid only for those expenses which have been approved as eligible by the federal Medicare program.

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

This policy's renewability, cancellability and termination provisions are at the option of the group policy holder except in cases of non-payment of premium

The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.

256973 05/20

Benefit Overview

Express Scripts Medicare® (PDP)

YOUR 2023 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Prescription Drug Plan Option 1:

<table>
<tr><td>Deductible stage</td><td colspan="4">$505.00</td></tr>
<tr><td rowspan="6">Initial Coverage stage</td><td colspan="4">After you pay your yearly deductible: You will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,660:</td></tr>
<tr><td>Tier</td><td>Retail One-Month (31-day) Supply</td><td>Retail Three-Month (90-day) Supply (Standard)</td><td>Home Delivery Three-Month (90-day) Supply</td></tr>
<tr><td>Tier 1:
Generic Drugs</td><td>15%</td><td>15%</td><td>10%</td></tr>
<tr><td>Tier 2:
Preferred Brand Drugs</td><td>30%</td><td>30%</td><td>25%</td></tr>
<tr><td>Tier 3:
Non- Preferred Brand</td><td>30%</td><td>30%</td><td>30%</td></tr>
<tr><td>Tier 4:
Specialty</td><td>25%</td><td>25%</td><td>25%</td></tr>
<tr><td colspan="4">If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy℠. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.</td></tr>
<tr><td>Coverage Gap stage</td><td colspan="4">After your total yearly drug costs reach $4,660, you will continue to pay the following, until you qualify for the Catastrophic Coverage stage:
- Brand-name drugs: You pay 25% of the total cost, plus a portion of the dispensing fee. (The manufacturer provides a 50% discount and the plan pays the difference)
- Generic Drugs: You pay 25% of the total cost</td></tr>
<tr><td>Non-part D Drugs</td><td colspan="4">Covered; Excluding lifestyle</td></tr>
<tr><td>Compound</td><td colspan="4">Compound Management Solution applies. Compound Management Solution is in place to mitigate compound drug abuse by means of inclusion and exclusion lists</td></tr>
<tr><td>Catastrophic Coverage stage</td><td colspan="4">After your yearly out-of-pocket drug costs reach $7,400, you will pay the greater of 5% coinsurance or:
• a $4.15 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage
• an $10.35 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.</td></tr>
</table>

Benefit Overview

Express Scripts Medicare® (PDP)

YOUR 2023 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Prescription Drug Plan Option 2:

<table>
<tr><td>Deductible stage</td><td colspan="4">$100.00</td></tr>
<tr><td rowspan="6">Initial Coverage stage</td><td colspan="4">After you pay your yearly deductible: You will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,660:</td></tr>
<tr><td>Tier</td><td>Retail One-Month (31-day) Supply</td><td>Retail Three-Month (90-day) Supply (Standard)</td><td>Home Delivery Three-Month (90-day) Supply</td></tr>
<tr><td>Tier 1:
Generic Drugs</td><td>15%</td><td>15%</td><td>10%</td></tr>
<tr><td>Tier 2:
Preferred Brand Drugs</td><td>30%</td><td>30%</td><td>25%</td></tr>
<tr><td>Tier 3:
Non- Preferred Brand</td><td>50%</td><td>50%</td><td>50%</td></tr>
<tr><td>Tier 4:
Specialty</td><td>25%</td><td>25%</td><td>25%</td></tr>
<tr><td colspan="4">If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy℠. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.</td></tr>
<tr><td>Coverage Gap stage</td><td colspan="4">After your total yearly drug costs reach $4,660, you will continue to pay the following, until you qualify for the Catastrophic Coverage stage:
- Brand-name drugs: You pay 25% of the total cost, plus a portion of the dispensing fee. (The manufacturer provides a 50% discount and the plan pays the difference)
- Generic Drugs: you will continue to pay the same cost-sharing amount as in the Initial Coverage stage</td></tr>
<tr><td>Non-part D Drugs</td><td colspan="4">Covered; Excluding lifestyle</td></tr>
<tr><td>Compound</td><td colspan="4">Compound Management Solution applies. Compound Management Solution is in place to mitigate compound drug abuse by means of inclusion and exclusion lists</td></tr>
<tr><td>Catastrophic Coverage stage</td><td colspan="4">After your yearly out-of-pocket drug costs reach $7,400, you will pay the greater of 5% coinsurance or:
• a $4.15 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage
• an $10.35 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.</td></tr>
</table>

Benefit Overview

Express Scripts Medicare® (PDP)

YOUR 2023 PRESCRIPTION DRUG PLAN BENEFIT

Here is a summary of what you will pay for covered prescription drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through our home delivery service.

Prescription Drug Plan Option 3:

<table>
<tr><td>Deductible stage</td><td colspan="4">$100.00</td></tr>
<tr><td rowspan="7">Initial Coverage stage</td><td colspan="4">After you pay your yearly deductible: You will pay the following until your total yearly drug costs (what you and the plan pay) reach $4,660:</td></tr>
<tr><td>Tier</td><td>Retail One-Month (31-day) Supply</td><td>Retail Three-Month (90-day) Supply (Standard)</td><td>Home Delivery Three-Month (90-day) Supply</td></tr>
<tr><td>Tier 1:
Generic Drugs</td><td>15%</td><td>15%</td><td>10%</td></tr>
<tr><td>Tier 2:
Preferred Brand Drugs</td><td>30%</td><td>30%</td><td>25%</td></tr>
<tr><td>Tier 3:
Non- Preferred Brand</td><td>40%</td><td>40%</td><td>35%</td></tr>
<tr><td>Tier 4:
Specialty</td><td>25%</td><td>25%</td><td>25%</td></tr>
<tr><td colspan="4">If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through the Express Scripts Pharmacy℠. There is no charge for standard shipping. Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.</td></tr>
<tr><td>Coverage Gap stage</td><td colspan="4">After your total yearly drug costs reach $4,660, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage.</td></tr>
<tr><td>Non-part D Drugs</td><td colspan="4">Covered; Excluding lifestyle</td></tr>
<tr><td>Compound</td><td colspan="4">Compound Management Solution applies. Compound Management Solution is in place to mitigate compound drug abuse by means of inclusion and exclusion lists</td></tr>
<tr><td>Catastrophic Coverage stage</td><td colspan="4">After your yearly out-of-pocket drug costs reach $7,400, you will pay the greater of 5% coinsurance or:
• a $4.15 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage
• an $10.35 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.</td></tr>
</table>

IMPORTANT PLAN INFORMATION

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact the plan or the Retiree Customer Service Center for more details.

Additional Information About This Coverage

- The service area for this plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this plan.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.
- To find a network pharmacy near you, visit our website at **www.Express-Scripts.com**.
- Your plan uses a formulary – a list of covered drugs. The amount you pay depends on the drug's tier and on the coverage stage that you've reached. From time to time, a drug may move to a different tier. If a drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- To access your plan's list of covered drugs, visit our website at **www.Express-Scripts.com**.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- Each month, you <u>may</u> need to pay a monthly premium amount to continue your participation in this plan. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

DELTA DENTAL®

Delta Dental PPO (Standard)
Summary of Dental Plan Benefits
For Group# 0414-0001
DePauw University Retirees

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Indiana

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays*	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to prosthetic appliances	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%

* When you receive services from a Delta Dental Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Three oral exams (including evaluations by a specialist) are payable per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This

program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,500 per person total per Benefit Year on all services except orthodontic services.

Deductible – $100 Deductible per person total per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first day of the month following the qualification for DePauw University retirement benefits.

Eligible People – All qualified retirees of DePauw University and their eligible dependents who choose the dental plan during an election period and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable.

Also eligible at your option are your legal spouse. You and your legal spouse must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your legal spouse may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your legal spouse are both eligible for coverage under this Policy, you may be enrolled together on one application or separately on individual applications, but not both. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Policy.

Benefits will cease on the last day of the month in which the employee is terminated.

Blue View Vision℠

DePauw University – (Post 65 Population)
Plan FS.B.10.10.130.130

Anthem. BlueCross BlueShield

Effective 01/01/2023

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $42 reimbursement	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $45 reimbursement	Once every two calendar years
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses	 $10 copay $10 copay $10 copay	 Up to $40 reimbursement Up to $60 reimbursement Up to $80 reimbursement	Once every calendar year
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
• Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory scratch coating	$0 copay $0 copay $0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
• Elective conventional (non-disposable) OR • Elective disposable OR • Non-elective (medically necessary)	$130 allowance, then 15% off any remaining balance $130 allowance *(no additional discount)* Covered in full	Up to $105 reimbursement Up to $105 reimbursement Up to $210 reimbursement	Once every calendar year

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	○ Transitions lenses (Adults)
	○ Standard Polycarbonate (Adults)
	○ Tint (Solid and Gradient)
	○ UV Coating
	○ Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	○ Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	○ Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	○ Complete Pair ○ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	○ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	○ Standard contact lens fitting[3] ○ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	○ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | TARGET OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111

MONTHLY PAYMENT SUMMARY

2023 Monthly Rates*				
	Amount You Pay Delta Dental Plan	**Amount You Pay Medical + Rx Low Plan Option 1**	**Amount You Pay Medical + Rx Mid Plan Option 2**	**Amount You Pay Medical + Rx High Plan Option 3**
Ages 65-69	**$14.60**	**$39.52**	**$51.95**	**$164.13**
Ages 70-74	**$14.60**	**$39.52**	**$101.69**	**$214.01**
Ages 75 +	**$14.60**	**$91.97**	**$160.35**	**$272.80**

*** Per Person Covered**

Vision Plan	
	Amount you Pay
Retiree	$8.08
Retiree + Spouse	$12.66

A check for your first monthly payment is required.

Mail a check for your first month's premium to:
DePauw University/Amwins Group Benefits, Inc., 50 Whitecap Drive, North Kingstown, RI 02852

Make your check payable to:
DePauw University/Amwins Group Benefits, Inc.

If you are interested in monthly automatic withdrawals from your bank account, complete the Direct Payment Authorization form and return it with a voided check and a check for your first month's payment.

If you do not sign up for automatic payments, you will begin receiving monthly invoices from Amwins. Please return a check for your first month's payment in the enclosed return envelope. Payments are due on the 1st of every month.

RETIREE MEDICAL PLAN ELECTION FORM

DePauw University

Medical plan is underwritten by: Transamerica Life Insurance Company
Dental Plan is underwritten by: Delta Dental
Vision Plan is underwritten by: Anthem

You must return your election form to put your coverage in force!			
Retiree Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Gender	Phone Number
State	Zip Code	Medicare ID# *(from Medicare ID card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	
Email Address		Date of Retirement	
Spouse Information (if enrolling)			
Name		Date of Birth	
Gender		Social Security Number	
Date of Retirement		Medicare ID# *(from Medicare ID card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	

Please Choose Type of Coverage

Effective Date: ___/01/2023 ***Check Desired Coverage*:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical Plan			
Delta Dental Plan			
Anthem Vision Plan			

Please Check box for VEBA Payment, if Applicable:

I would like my monthly premium to be deducted from my VEBA account: ☐Yes ☐No

(continue to next page)

RETIREE MEDICAL PLAN ELECTION FORM

Please Complete the Following Information:
Do you (or your spouse, if enrolling) currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?

Retiree (if enrolling): ☐ Yes ☐ No Spouse (if enrolling): ☐Yes ☐No
a) If YES*, with which company? _____
b) What kind of policy / certificate? _____
c) Length of time you have had coverage? _____ Years_____ Months_____
d) Will you be replacing the above listed policy/certificate upon acceptance of this enrollment form?
☐ Yes ☐ No
*I understand it is my responsibility, if I desire to do so, to cancel my current coverage, if any, by notifying the Provider or Plan Administrator of such coverage.

FRAUD WARNING

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Warning:
AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

MD Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD.

DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(continue to next page)

RETIREE MEDICAL PLAN ELECTION FORM

Release of Information:
By joining this medical plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled.

I understand that my signature (or that of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare.

Date:	**Retiree Signature:**
Date:	**Spouse/Surviving Spouse Signature:**

If you are an authorized representative, you must sign above and provide the following information:

Name:_____

Address:_____

Phone Number:_____

Relationship to Retiree:_____

Please return signed election form to:
Amwins Group Benefits
50 Whitecap Drive, North Kingstown, RI 02852

For Customer Service, please call: 1-888-883-3757
Monday through Friday, 8:00 AM to 8:00 PM EST

MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
SPONSORED GROUP PLAN

To enroll in Express Scripts Medicare® (PDP)
please provide the following information:

Group Name: DePauw University **Desired Effective Date:**

Retiree			
Last Name:	First Name:		Middle Initial:
☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)		
Sex: ☐ M ☐ F	Social Security Number:	Home Phone Number: ( )	
E-Mail Address:			
Permanent Resident Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:
Spouse or Surviving Spouse			
Last Name:	First Name:		Middle Initial:
☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)		
Sex: ☐ M ☐ F	Social Security Number:	Home Phone Number: ( )	
E-Mail Address:			
Permanent Resident Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:
Emergency Contact: (Optional)			
Name:			
Phone Number:	Relationship to you:		
E-Mail Address:			

Continued next page

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
  - OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Retiree:	Spouse or Surviving Spouse:
Name: _____	Name: _____
Medicare Number __ __ __ __ - __ __ __ - __ __ __ __	**Medicare Number** __ __ __ __ - __ __ __ - __ __ __ __
OR Medicare Claim Number __ __ __ - __ __ - __ __ __ __ - __ __	**OR Medicare Claim Number** __ __ __ - __ __ - __ __ __ __ - __ __
Is Entitled To **Effective Date** HOSPITAL (Part A) _____ MEDICAL (Part B) _____	**Is Entitled To** **Effective Date** HOSPITAL (Part A) _____ MEDICAL (Part B) _____

Select Your Enrollment Options Below (Please Check Desired Coverage)

Please check which plan you want to enroll in:

Retiree:	Spouse or Surviving Spouse:
☐ Option 1 ☐ Option 2 ☐ Option 3	☐ Option 1 ☐ Option 2 ☐ Option 3

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP) is offered by Medco Containment Life Insurance Company, which contracts with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

Enrollment Requirements
You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

Continued on next page

Important Information About Your Medicare Part D Prescription Drug Plan

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Express Scripts Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.

I also acknowledge that Express Scripts Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

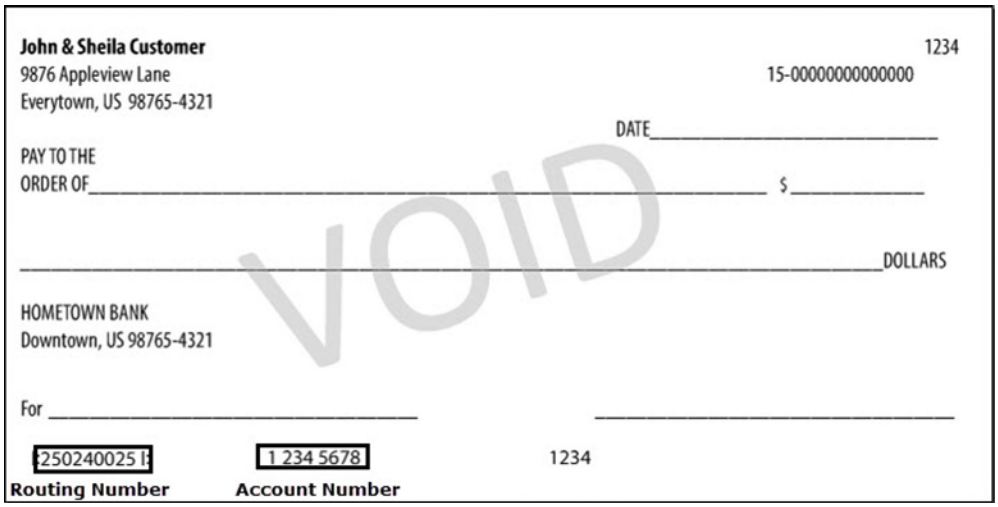
Retiree's Signature:	Today's Date:
Spouse or Surviving Spouse's Signature:	**Today's Date:**

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

DIRECT PAYMENT AUTHORIZATION FORM

Please read, sign and return with your Enrollment Forms

Name (Last, First, Middle Initial):		
Phone:		
Street Address:		
City:	**State:**	**Zip:**
Type of Account: ☐ **Savings** ☐ **Checking**	**Select Monthly Withdrawal Date:** ☐ **1st** ☐ **8th** ☐ **15th**	
Please fill in the below information:		
Routing Number:	**Account Number:** **Confirm Account Number:**	



Monthly payments are withdrawn on the 1st business day on or after the date you selected above. You will receive a confirmation from Amwins Group Benefits that we have set up your account information to withdraw from your designated bank account. ***Note:*** Your monthly deduction will show as **Amwins** on your bank statement.

I authorize Amwins to withdraw my payment as communicated to me, by invoice or letter, from my checking or savings account. I agree to notify Amwins in writing or by phone, if my account information changes or to stop the direct debit authorization at least 10 days in advance of the scheduled transfer. I understand that the premium to be withdrawn may change, in which case I will be notified in writing at least 10 days before the new premium is withdrawn. To the extent I have enrolled in preauthorized checking, I understand that the addition or removal of a dependent will impact the amount withdrawn, and hereby consent to such change. I understand that Amwins will confirm the new preauthorized amount, but depending on when I submit this request, such confirmation may occur after the amounts are withdrawn from my account. If my account is erroneously charged, my financial institution will immediately credit the same amount to the account up to the 15 days following issuance of the statement or 45 days after posting, which occurs first.

Signature:	Date:

WAIVER of COVERAGE

If you DO NOT wish to enroll in the DePauw University Plan(s), please complete, sign and return this Waiver of Coverage form.

Retiree		Spouse (or Surviving Spouse)	
Name:		Name:	
Address:		Address:	
City:		City:	
State:	Zip Code:	State:	Zip Code:

Please Sign & Date Below:	
NO, DO NOT ENROLL ME (us) in the DePauw University Plan(s). I (we) understand that by choosing this option, I am (we are) declining medical and prescription drug coverage, and may or may not be able to re-enroll at a later date.	
Retiree:	Date:
Spouse (or Surviving Spouse):	Date:
All applicable signatures are required for individuals declining coverage in the Plan.	

Reason for Declining Coverage:

ANSWERS to YOUR QUESTIONS

Q: Who can I call if I have questions?
A: Please contact the Amwins Group Benefits Customer Care Center toll-free at **1-888-883-3757**, Monday through Friday, from 8 a.m. to 8 p.m. ET.

Q: How does the plan work?
A: Medicare has coverage gaps which are the costs that you must pay, like coinsurance, co-payments, and deductibles. This plan helps fill those gaps. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and then your plan pays based on your plan's benefits. You will receive a Medicare Summary Notice in the mail (in most cases each month), including information on the amount paid on your behalf and any additional amount due.

Q: Can my age 65 spouse enroll if I am not yet age 65?
A: Yes. As long as your spouse is eligible to participate in the Program and is age 65 or over. As soon as you become Medicare eligible, you can enroll on the first day of the month in which you reach your 65th birthday.

Q: My spouse is not yet 65. What will happen to coverage for my spouse after I enroll in this plan?
A: Your spouse will continue coverage under the pre-Medicare early retiree plan. Two months prior to your spouse attaining age 65, a Medicare enrollment packet will be mailed. At that time, your spouse should contact Social Security to enroll in Medicare Parts A and B in order to be eligible to enroll in the group Medicare Plan.

Q: Will I have to re-enroll in the Plan next year?
A: No, once you enroll, you remain in the plan until you elect or terminate coverage.

Q: When will I receive my ID Cards?
A: ID cards will be sent once we process your enrollment materials. Medical and Prescription Drug ID cards will arrive in two separate packages.

Q: How are my medical claims paid?
A: As long as your physician accepts Medicare you will not have to send in any claim forms. Present your ID card along with your Medicare card to your doctor. Medicare pays the provider of the Medicare portion of your claim and forwards the balance due to the claims administration department. Remaining amounts will be billed to you.

Q: Do I still need my Medicare ID Card?
A: Yes. You will continue to use your Medicare ID card with this plan in conjunction with your Plan ID card.

Q: Do my prescription drug co-payments count toward my medical plan deductible?
A: No. Any co-payments you make for prescription drugs do not count toward deductibles or out of pocket maximum amounts for your medical plan.

Q: How do I get my prescriptions filled?
A: Simply present your ID card and prescription to a participating pharmacy in the plan network. You will also receive information about mail order prescriptions when you enroll. You can find more information about your prescription coverage by visiting www.Express-Scripts.com or by calling Amwins Group Benefits at **1-888-883-3757**.

Q: Where can I get information on using Mail Order Services?
A: Once you enroll in the plan, you will receive a fulfillment kit in the mail which will include mail order through the Express Scripts Pharmacy. Please be aware that you will need to obtain new prescriptions from your Doctor before ordering prescriptions from this new mail order program. The necessary forms and instructions on how to order prescriptions through the mail order service will be included in your fulfillment packet. Please expect your package and materials to arrive shortly before your plan effective date.

ANSWERS to YOUR QUESTIONS

Q: How can I find out if my drugs are covered on the new plan?
A: You will receive a copy of the formulary (List of Covered Drugs) in your fulfillment packet once you enroll. Some covered drugs may have additional requirements or limits on coverage. You can find out if your drug has any additional requirements or limits by reviewing the formulary. If your drug is not included on the formulary, you should first contact us and ask if your drug is covered. Please contact Amwins Group Benefits Customer Care toll-free at **1-888-883-3757** or visit **www.Express-Scripts.com** for more information about your prescriptions.

Q: How can I lower my drug expenses?
A: Generic medications often cost less than brand-name counterparts. Talk to your doctor to determine if a generic is available. You may also have the option of mail order, where you can receive up to a 90-day supply for one mail order co-payment.

Q: What services are not covered?
A: Services not covered by Medicare are not covered by this plan. Please contact us for the Medicare exclusion list. You may also call 1-800-MEDICARE or visit www.medicare.gov.

Q: If I choose not to enroll this year, can I enroll next year?
A: Yes, you will have the opportunity to enroll in the group plan at the next open enrollment, or if you have a qualified family status change.

Q: Do I have the option to enroll in just medical or prescription drug coverage or do I have to enroll in both plans?
A: The Amwins health benefit plan combines two separate plans into one package which includes both medical and prescription drug coverage. You may not elect the prescription drug coverage without participating in the medical plan, or vice versa. The premium for medical insurance includes the prescription drug benefit.

Q: How do I pay for my coverage?
A: Your premium is deducted from your retiree benefit check.

Q: Can I enroll in a separate Medicare Part D plan and the Amwins medical and prescription plan?
A: No. You cannot enroll in two Medicare Part D plans. If you enroll in a separate Medicare Part D plan, you are not eligible to enroll in the Amwins medical plan and prescription drug plan.

Q: How do I obtain a replacement ID card for my plans?
A: Call Amwins Group Benefits at **1-888-883-3757**, Monday through Friday, from 8 a.m. to 8 p.m. EST.

Q: What happens to coverage for a spouse if the retiree dies?
A: The spouse or family member of the retiree should notify Amwins as soon as possible. The Surviving Spouse will have the option to remain on the plans. Amwins will direct bill the surviving spouse for the monthly premium due.

DEPAUW
UNIVERSITY
Est. 1837

Disclaimer: The benefit information contained in this brochure is subject to change at any time, and the University reserves the unlimited right to make benefit plan changes at any time. Any changes to the benefit plans implemented by the University will be considered effective, regardless of whether notice has been given, on the date set by the University. If you are ever in doubt about your retiree medical benefits, please contact Amwins Group Benefits at 1-888-883-3757.