The George Washington University
Health and Welfare Benefit Plan
and
Summary Plan Description

Effective as of January 1, 2013
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SECTION 1

Introduction to Your Benefits
**Introduction**

The George Washington University (the “university”) is committed to offering its benefits-eligible employees a comprehensive benefits package at a competitive cost. GW offers employee benefits in a way that gives you choice and flexibility so that you can choose the benefits that are right for you and your family. To get the most out of the university’s benefits offerings, you will need to understand how the benefits work, when you can receive benefits, and what steps you must follow. This document, along with the applicable Benefits Descriptions, can help.

Each of these Benefit Options listed in the table below is summarized in an insurance contract, benefit booklet, certificate of coverage, or other governing document, referred to throughout this SPD as “Benefit Descriptions”. This document, together with any underlying Benefit Descriptions, is both the George Washington University Health and Welfare Benefit Plan (the “Plan”) and the Plan’s summary plan description (“SPD”), as required by the Employee Retirement Income Security Act (“ERISA”), as amended. The Plan offers you the choice of various levels of coverage so you can pick the level that best meets your needs. When you enroll during designated enrollment periods, we will ask you to make decisions about your benefits. That means you should evaluate your needs, learn about your options, and choose benefit levels that will protect you and any eligible family members for a full year.* (The university’s Plan year is the calendar year.)

This SPD does not address retirement plans or other non-ERISA welfare benefits (i.e., GW Paid Short Term Disability or tuition benefits). Summaries and information for these other benefits are available at http://benefits.gwu.edu, or by calling (888) 4GWUBEN (449-8326).

For your reference, this SPD includes a glossary to help you navigate through some vocabulary (see Section 7). Capitalized terms in this SPD are defined in the glossary.

**Benefit Options**

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Coverage Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
</tr>
<tr>
<td>(includes prescription drug coverage through CVS Caremark)</td>
<td>UnitedHealthcare Choice&lt;br&gt;UnitedHealthcare Choice Plus – Buff&lt;br&gt;UnitedHealthcare Choice Plus – Blue</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aetna High Option Dental PPO&lt;br&gt;Aetna Low Option Dental PPO&lt;br&gt;Aetna DMO (Dental Maintenance Organization)</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare Basic Vision&lt;br&gt;UnitedHealthcare Enhanced Vision</td>
</tr>
<tr>
<td><strong>Life and Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</strong></td>
<td>Basic Group Term Life Insurance&lt;br&gt;Basic AD&amp;D Insurance</td>
</tr>
</tbody>
</table>

* For those who have qualified life events or terminate employment from the university during the year, other time periods will apply. Please see Section 2 for information on participation.
### Important Notes on the Benefit Descriptions

*This SPD and the booklets, certificates, and other descriptive material provided or made available to you by the university and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other materials (such as an insurance policy or other contractual agreement with a healthcare or other service provider) that contain more detailed information about Plan benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan’s benefits. However, if there is any conflict or inconsistency among these materials, it is the Plan Administrator’s responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. The university reserves the right to change, amend, or terminate the Plan and any of the Benefit Options at any time and for any reason. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the university and does not give you the right to be retained in the employment of the university. No one speaking on behalf of the Plan or the university can alter the terms of the Plan. You and your beneficiaries may obtain copies of this Plan document and SPD and the Benefit Descriptions, or examine these documents by contacting the Plan Administrator at the number and address set forth in Section 6 below.*

Throughout this document, you will be referred to a dedicated call center that is available to assist you with any questions or concerns that you may have about your benefit options, which you can reach by calling (888) 4GWUBEN (449-8326) or by calling a particular vendor that has partnered with the university to provide benefits. In addition, you may contact the university’s Benefits Administration Department at (703) 726-8382 or [http://benefits.gwu.edu](http://benefits.gwu.edu).
SECTION 2

Eligibility, Enrollment, and Participation
Key Definitions

Benefits-Eligible Employee – Any individual on the payroll of the university, and not paid by accounts payable, whose wages from the university are subject to withholding for the purposes of federal income taxes and the Federal Insurance Contributions Act. The term Benefits-Eligible Employee shall not include:

- a student, including a fellow, graduate teaching assistant or other person whose employment is incidental to his or her educational program, as determined by the university;
- a Faculty Member who is appointed on a temporary basis as a part-time lecturer or professorial lecturer of one-semester (or less) or paid on a per-course basis;
- a member of a collective bargaining unit unless such member is covered by a collective bargaining agreement that expressly provides for participation in the Plan;
- a nonresident alien with no U.S. source earned income (as that term is described in Code section 410(b)(3)(C));
- a leased employee;
- an individual whom the university classifies as a temporary employee, independent contractor, contract worker, casual employee, or consultant (regardless of the individual’s employment status under applicable law);
- any person who is regularly scheduled to work less than 14 hours per week; or
- any person excluded from participation under the terms of the Benefit Descriptions.

Faculty Member –

- Full-Time Faculty Member – A Benefits-Eligible Employee who is appointed for at least one academic year in one of the regular, visiting, special service, or research ranks listed in the Faculty Code, who devotes 100% effort, and who receives full salary through the university. Faculty appointed on a temporary basis (one semester or less) are not included. Full-Time Faculty Member also includes a Partial Retiree as provided in the Faculty Code, which is a Benefits-Eligible Employee who is a Full-Time Faculty Member who reduces their workload to either a two-thirds or a half-time basis. Such Partial Retiree will continue to be eligible for benefits as a Full-Time Faculty Member during the partial retirement period.

- Part-Time Faculty Member – A Benefits-Eligible Employee who is appointed for at least an academic year, who devotes at least one-third time to university duties, and is compensated at no less than one-third of a full-time equivalent salary for that period. Part-time faculty who are on one-semester appointments or who are compensated on a per-course basis are not included.

Resident – A Benefits-Eligible Employee who serves as a medical resident.

Staff Member – A Benefits-Eligible Employee of the university who is a regular full-time or regular part-time, graded or ungraded employee, who is not classified as a Faculty Member.
- **Full-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 40 hours per week. *

- **Part-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 14 hours a week but less than 40 hours per week.

Note: Additional definitions used in this SPD can be found in the Glossary in Section 7.

**Eligibility for Coverage**

Only a Benefits-Eligible Employee and their eligible Dependents may receive Plan benefits. For Medical Benefit purposes, Dependents must reside within the United States in order to be eligible. To determine whether you are eligible to participate in a Benefit Option, please read the eligibility information contained in the following eligibility chart. For complete information regarding eligibility, you should also refer to the underlying Benefit Descriptions available at benefits.gwu.edu.

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit (including prescription drug)</td>
<td>Full-Time and Part-Time Faculty and Staff Members are eligible on the first of the month following or coincident with their date of hire.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Residents are eligible for Medical Benefits on their date of hire. Eligibility for remaining benefits is on the first of the month following or coincident with date of hire.</td>
</tr>
<tr>
<td>Vision Benefit</td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Benefit</td>
<td></td>
</tr>
<tr>
<td>Legal Benefit</td>
<td></td>
</tr>
<tr>
<td>Life and AD&amp;D Insurance Benefit</td>
<td>The following Benefits-Eligible Employees are eligible on the first of the month following or coincident with their date of hire:</td>
</tr>
<tr>
<td></td>
<td>- Full-Time and Part-Time Faculty Members</td>
</tr>
<tr>
<td></td>
<td>- Full-Time Staff Members</td>
</tr>
<tr>
<td></td>
<td>- Residents</td>
</tr>
<tr>
<td></td>
<td>Part-Time Staff Members are eligible on the first of the month following 6 months of continuous service.</td>
</tr>
</tbody>
</table>

* Benefits-Eligible Employees at the GW Biostatistics Center who work 34 or more hours a week are considered Full-Time Staff for purposes of benefits.
Eligibility Chart for Faculty Members, Staff Members and Residents

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Disability Insurance Benefit</td>
<td>Full-Time Faculty and Full-Time Staff Members and Residents are eligible on the first of the month following or coincident with one year of continuous service unless they verify prior long-term disability insurance coverage with a previous employer in the 12 months immediately preceding their date of hire. Those with prior coverage are eligible on the first of the month following or coincident with their date of hire. Part-Time Faculty Members and Part-Time Staff Members are not eligible.</td>
</tr>
<tr>
<td>Short-Term Disability Insurance Benefit (Voluntary STD)</td>
<td>Full-Time Faculty and Full-Time Staff Members with less than two years of benefit-eligible service are eligible on the first of the month following or coincident with their date of hire. Part-Time Faculty Members are eligible on the first of the month following or coincident with their date of hire. Part-Time Staff Members are eligible on the first of the month following 6 months of continuous service.</td>
</tr>
</tbody>
</table>

**Dependents Eligible for Coverage**

Benefits-eligible employees may enroll eligible Dependents in the Medical, Dental, Vision, Supplemental Life and/or AD&D Insurance (if you also select Supplemental Life and/or AD&D Insurance for yourself), and Legal Benefits. Dependents are automatically covered for Employee Assistance Benefits.

Eligible Dependents include:

- your Spouse (including common law marriage or same-sex marriage) or Domestic or Civil Union Partner;
- your or your Spouse/Domestic or Civil Union Partner’s child up to the end of the month in which the child reaches age 26; and
- for certain Benefit Options, your or your Spouse/Domestic or Civil Union Partner’s child beyond age 26 if the child is incapable of self-support and is dependent upon you because of a mental or physical condition.

A child includes a biological child, stepchild, child placed with you for adoption, legally adopted child, the biological or adopted child of your covered Domestic or Civil Union Partner, and a child for whom you are the legal guardian. **Note:** In the case of legal guardianship, there may be restrictions on the types of coverage available for the child.

In order to cover your eligible Dependents, you must submit documentation verifying that they are eligible under the Benefit Option rules. Shortly after you enroll a Dependent(s), you will receive an email from the Benefits Administration Department with full details on what documentation is required.
when it must be provided, and where to send it. Your Dependent(s) will not be covered until the university receives this required documentation. If you fail to provide the required documentation, your Dependent(s) will not be enrolled.

The following documents (including any supporting documentation listed in the declarations) are required to verify eligibility for the following Dependents:

- Spouse – marriage certificate
- Domestic Partner – “Declaration of Domestic Partnership” and required documents as listed in the declaration
- Civil Union Partner – civil union certificate or license
- Child – birth certificate or other proof of birth, adoption or guardianship

**If You and Your Dependents Both Work at GW**

No individual may be enrolled in the same Benefit Option as both a Participant and a Dependent, and no individual may be covered as a Dependent by more than one Participant.

**If a Covered Dependent Becomes Ineligible for Coverage**

You are required to notify GW within 30 calendar days if your covered dependent no longer satisfies the criteria to be a covered dependent. For example, if you become divorced, your marriage is annulled, or you dissolve your Domestic Partnership or Civil Union. If you fail to timely cancel coverage for a former covered dependent, you may be held accountable for claims paid in error and you may have imputed income for the value of the ineligible coverage. For information on imputed income, please see Section 3. For information on how your former covered dependent may continue certain medical coverage, please see Section 4.

**Dissolution of Domestic Partnership or Civil Union**

Within 30 calendar days following the dissolution of a Domestic or Partnership or Civil Union, you must provide the Benefits Administration Department with written notice of such occurrence. To do so, you must complete and return a “Dissolution of Domestic Partnership” form available from the Benefits Administration Department or provide a copy of a court approved petition, order or other state record with evidence that your Civil Union license or certificate has been dissolved. You should keep a copy of such notice for your records and provide a copy to your former Domestic or Civil Union Partner. A failure to provide such notice could result in the Plan or a Benefit Option paying benefits that are not appropriate under the circumstances and will provide the Plan or Benefit Option with a cause of action against you for recovery of the cost to the Plan or Benefit Option of such benefits and any related expenses. Any employer, company, insurer, claims administrator, or other person or entity that suffers harm or loss due to inappropriate receipt of benefits by you or your former Domestic or Civil Union Partner may bring a civil action against you, your former Domestic or Civil Union Partner, or both, to recover their losses, including reasonable attorney’s fees.

**Enrolling in the Plan: Initial Eligibility**

You must enroll via the university’s online enrollment tool called EasyEnroll, which can be accessed at http://benedetails.gwu.edu, within 30 calendar days of the date you and/or your Dependent(s) become
eligible (which is often 30 calendar days following your date of hire) to make elections for a Benefit Option of the Plan. If you do not enroll within this initial eligibility period, you may later enroll during the open enrollment period or within 30 calendar days of a qualifying life event. The university will notify you when the open enrollment period begins and ends.

**When Evidence of Insurability (EOI) is Required**

A supplemental life insurance or voluntary short-term disability insurance election after your initial eligibility period will require you to provide Evidence of Insurability (EOI) and coverage is dependent upon the insurance carrier approving your enrollment. In addition, life insurance coverage above the guaranteed issue amount also requires EOI, as explained below. EOI forms will be mailed to you when they are required and you must complete and return them within the time limits provided or you will have waived your enrollment opportunity.

**Supplemental Life Insurance EOI**

As a new hire, you can elect Supplemental Life Insurance coverage up to the guaranteed issue amount without EOI. The guaranteed issue is only applicable during your initial enrollment period. Amounts elected above the guaranteed issue amount will require EOI and you and your Spouse/Domestic or Civil Union Partner will be enrolled at the guaranteed issue amount until the EOI is approved.

For employees the guaranteed issue amount is the lesser of $200,000 or 5x your benefits salary. For your Spouse/Domestic or Civil Union Partner, the guaranteed issue amount is the lesser of $25,000 or 50% of your supplemental employee life insurance.

If you choose to wait and enroll in these supplemental coverages at a subsequent enrollment period (such as open enrollment), then you will be required to provide EOI at that time for any amount of coverage. However, if you previously elected at least $10,000 but less than $200,000 of supplemental employee life insurance coverage, you will be able to enroll for up to $200,000 without EOI. Any amount over $200,000 will require EOI. If you have previously elected at least $5,000 but less than $25,000 of supplemental Spouse/Domestic or Civil Union Partner life coverage (and you have elected at least $50,000 of supplemental employee life coverage), you will be able to elect up to $25,000 without EOI. Any amount over $25,000 will require EOI. If you previously elected at least $2,000 but less than $10,000 of child life coverage (and you have elected at least $20,000 of supplemental employee life coverage), you will be able to elect up to the maximum ($10,000) without EOI.

**Voluntary Short-Term Disability Insurance EOI**

If you do not enroll in voluntary short-term disability insurance when you are first eligible and elect coverage for the first time at a later date, including open enrollment, then you will be required to provide EOI at that time.
**Open Enrollment**

The university will notify you when the open enrollment period begins and ends. More information will be provided then. In general, if you were previously enrolled under a Benefit Option of the Plan and you do not make a change online during open enrollment, then your previous benefit elections under the Plan will carry over to the next year. You will not be able to make any changes to these elections until the next open enrollment or if you experience a subsequent qualifying life event.

**Changing Your Benefits During the Year**

Assuming you are still eligible for benefits and you experience a qualifying life event, you can make changes outside of open enrollment within 30 calendar days of a qualifying life event. Generally, changes must be on account of, and correspond with, the life events described in the following table.

<table>
<thead>
<tr>
<th>QUALIFYING LIFE EVENTS</th>
<th>Add Employee</th>
<th>Add Spouse/ Domestic or Civil Union Partner</th>
<th>Add Child</th>
<th>Drop Employee</th>
<th>Drop Spouse/ Domestic or Civil Union Partner</th>
<th>Drop Child</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage/ Domestic or Civil Union Partnership*</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES**</td>
<td>Marriage Certificate and Birth Certificate if child also added</td>
</tr>
<tr>
<td>Divorce/Legal Separation or Dissolution of Domestic or Civil Union Relationship</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES (if not your Dependent)</td>
<td>Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership</td>
</tr>
<tr>
<td>Birth or Adoption* (including a court order to add a child)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Birth Certificate, Proof of Birth or Adoption Papers</td>
</tr>
<tr>
<td>Guardianship</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Legal Papers</td>
</tr>
<tr>
<td>Significant Change in Coverage due to Participant’s Change in Employment Status</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>None since the university has records</td>
</tr>
<tr>
<td>Family Status Change</td>
<td>Add Employee</td>
<td>Add Spouse/Domestic or Civil Union Partner</td>
<td>Add Child</td>
<td>Drop Employee</td>
<td>Drop Spouse/Domestic or Civil Union Partner</td>
<td>Drop Child</td>
<td>Required Documentation</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------</td>
<td>------------------------------------------</td>
<td>-----------</td>
<td>---------------</td>
<td>----------------------------------------------</td>
<td>------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Spouse/Domestic or Civil Union Partner’s Employment Termination* or Significant Change in Coverage Due to Change in Employment Status Affecting Eligibility (such as changing from Full-Time to Part-Time)*</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)</td>
</tr>
<tr>
<td>Spouse/Domestic or Civil Union Partner Becomes Covered by His/Her Employer</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Benefit Coverage from Employer</td>
</tr>
<tr>
<td>Dependent Becomes Ineligible (reached maximum age)</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>No Documentation Required</td>
</tr>
<tr>
<td>Death of Spouse/ Domestic or Civil Union Partner</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>Death Certificate</td>
</tr>
<tr>
<td>Death of Eligible Dependent</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>Death Certificate</td>
</tr>
<tr>
<td>Medicaid Eligibility</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES*</td>
<td>YES*</td>
<td>Proof of Eligibility or Enrollment</td>
</tr>
<tr>
<td>Loss of Other Coverage* (but not due to a failure to pay COBRA premium)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Loss of Eligibility for Medicaid</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Children’s Health Insurance Plan Eligibility</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>Proof of Eligibility or Enrollment</td>
</tr>
</tbody>
</table>
## QUALIFYING LIFE EVENTS

<table>
<thead>
<tr>
<th>Family Status Change</th>
<th>Add Employee</th>
<th>Add Spouse/Domestic or Civil Union Partner</th>
<th>Add Child</th>
<th>Drop Employee</th>
<th>Drop Spouse/Domestic or Civil Union Partner</th>
<th>Drop Child</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Eligibility for Children’s Health Insurance Plan</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Spouse/Domestic or Civil Union Partner Makes Changes At Open Enrollment***</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss or Benefit Coverage from Employer</td>
</tr>
<tr>
<td>Increase in Cost Due to Change From Full-Time to Part-Time</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>No Documentation Required (if Benefits-Eligible Employee)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO</td>
<td>(if Spouse/Domestic or Civil Union Partner)</td>
</tr>
<tr>
<td>Decrease in Cost Due to Change From Part-Time to Full-Time</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>No Documentation Required (if Benefits-Eligible Employee)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO</td>
<td>(if Spouse/Domestic or Civil Union Partner)</td>
</tr>
</tbody>
</table>

*If you are enrolling based on one of these events, you will have the opportunity to change coverage levels or options.

**This change is permitted if the Benefits-Eligible Employee drops coverage.

***This change must be consistent with the change made under a Benefits-Eligible Employee’s Spouse’s/Domestic or Civil Union Partner’s plan.
Other Requirements

To be eligible to change your benefits following a qualifying life event, you generally must report the event within 30 calendar days of the event online via EasyEnroll, which can be accessed at http://benedetails.gwu.edu. (If you are adding or dropping a dependent due to a divorce or legal separation or due to eligibility or loss of eligibility for Medicaid or the Children’s Health Insurance Plan, you have 60 calendar days to report the event.) You may be asked to submit any necessary documentation (as applicable) related to the qualifying life event. However, do not wait until you receive documentation before enrolling; you must report the event within 30 calendar days of the event or it will be treated as a late enrollment and you will be required to wait until the next open enrollment period.

The Plan Administrator reserves the right to determine whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such event. Remember that you may only make changes that are consistent with the change in your family status.

Effective Date of Change

If the event is birth, adoption, placement for adoption, adding a dependent due to court order, or death of a Dependent, then the benefit elections will take effect on the date of the event.

If the event is a Dependent child becomes ineligible (for example, reaching the maximum age), then the benefit elections will take effect at the end of the month in which the event occurred.

In the event of a change in your employment status (such as moving from full-time to part-time or going on leave of absence), your new benefit elections will take effect on the first day of the month following or coincident with the event, provided you submit all required documentation.

In all other instances, your elections will take effect on the first day of the month following the date you submit all required documentation. For example, if you were to marry on the event date shown and submit a request to add your new spouse to your medical coverage:

<table>
<thead>
<tr>
<th>Event Date</th>
<th>And all required paperwork is received on:</th>
<th>The change will take effect on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 15</td>
<td>September 30</td>
<td>October 1</td>
</tr>
<tr>
<td>September 15</td>
<td>October 10</td>
<td>November 1</td>
</tr>
<tr>
<td>September 15</td>
<td>October 17</td>
<td>You have missed the 30-calendar day deadline and may not add your spouse to your coverage until during the next open enrollment period to be effective January 1.</td>
</tr>
<tr>
<td>October 1</td>
<td>September 29</td>
<td>October 1</td>
</tr>
<tr>
<td>October 1</td>
<td>October 5</td>
<td>November 1</td>
</tr>
</tbody>
</table>
Special Enrollment Rights

If you decline enrollment for yourself or your Dependents (including your Spouse/Domestic or Civil Union Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in the medical, dental, and vision coverage if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents’ other coverage). However, you must request enrollment within 30 calendar days after your or your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Newly Eligible Children

If you decline enrollment for yourself or your Dependents (including your Spouse/Domestic or Civil Union Partner) and later have a newborn child, an adopted child, or a child placed with you for adoption, then you may be able to enroll yourself and your Dependents in the medical, dental, and vision coverage. You must request enrollment no later than 30 calendar days following the date of the event to be eligible.

Please note that newborns are not automatically added to your coverage; you must take action for coverage to be effective. If you enroll a new child within 30 calendar days of the event, then the child’s coverage will be retroactive back to the date of the event. If you enroll a child after 30 calendar days, then coverage will only be prospective. You must provide supporting documentation when enrolling the child; however, do not wait to enroll your child until you receive the child’s social security number or birth certificate; you may submit other proof of birth.

Other Special Enrollment Rights

If you have a new Dependent as a result of marriage, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 calendar days after the marriage.

If you or your Dependent (1) loses coverage under Medicaid or the Children’s Health Insurance Program (“CHIP“)* as a result of a loss of eligibility for such coverage or (2) becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you will be able to enroll yourself and your Dependents in Health Coverage provided that a request for enrollment is made within 60 calendar days after the loss of such coverage or premium assistance eligibility.

To request special enrollment or obtain more information visit EasyEnroll, which can be accessed at http://benedetails.gwu.edu, or contact the call center at (888) 4GWUBEN (449-8326) or http://benefits.gwu.edu.

* The Children's Health Insurance Program (CHIP) provides free or low-cost health coverage for children up to age 19. Children in families with incomes up to $47,100/year (for a family of four) are likely to be eligible for coverage. In many states, families can have higher incomes and their children can still qualify. Call 1-877-KIDS-NOW (1-877-543-7669) for more information about CHIP.
When Participation Ends

Your participation in the Plan ends when you are no longer eligible for at least one Benefit Option. The date your coverage ends depends on the date you leave or become ineligible under the terms of each Benefit Option. See the Benefit Descriptions for specific information about when your coverage ends.

Your participation in the Plan shall end upon the earlier of the date:

- the Plan terminates;
- your employment with the university is terminated;
- you go on a leave of absence during which continued participation is not authorized by the terms of the Plan;
- you are laid off or go on strike; or
- you cease to satisfy the definition of “Benefits-Eligible Employee.”

Your participation in a Benefit Option shall end on the earlier of the date:

- you cease participating in the Plan;
- you discontinue participation in a Benefit Option during open enrollment;
- you fail to make a contribution required for a Benefit Option; or
- you cease to satisfy the conditions of a Benefit Option.

Notwithstanding the foregoing, the university may, in its sole discretion, cause your (or your Dependents’) coverage under the Plan or a Benefit Option to terminate if you or your Dependent:

- provides false information or makes misrepresentations in connection with a claim for benefits; permits an unauthorized person to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts, or omissions.

Your Dependent's participation in the Plan or a Benefit Option ends when your coverage ends or when he or she no longer satisfies the definition of an eligible Dependent (whichever happens first).

If you are Rehired

If your employment with the university is terminated and you are later rehired, then you will be treated as any other new hire except for the following Benefit Options:

- Life and AD&D Insurance: If you are rehired within 365 calendar days of your termination date, your previous service will apply toward the waiting period.

- Voluntary Short-Term Disability Insurance: If you are rehired within 365 calendar days of your termination date, your previous service will apply toward the waiting period.

- Long-Term Disability Buy-Up Insurance: If you are rehired within 365 calendar days of your termination date, your previous service will apply toward the waiting period.
If you are rehired within 30 calendar days, you may not change your election from the previous employment period.
SECTION 3

Benefits and Paying for your Benefits
Annual Choices

On an annual basis, the university allows you to choose the benefits that best meet your needs. You make your choices during the annual open enrollment period for the following Plan year. Your choices remain in effect for the full Plan year and may only be changed if you have a qualifying life event, as described in “Changing Your Benefits During the Year” beginning on page 12.

You select your coverage from a list of options provided by the university, as described below. The options provide varying levels of benefit protection. They also have different costs. You can choose an option that reflects the level of coverage that you need as well as how much you want to spend for coverage.

Available Options

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Explanation</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>You can choose from among the available Medical Benefit options or waive coverage. You can choose employee only, employee + Spouse/Domestic or Civil Union Partner (this may include a common-law marriage partner), employee + child(ren) (this includes you plus one or more children) or employee + family (this includes you, plus a Spouse/Domestic or Civil Union Partner and at least one other Dependent). Medical Benefit Participants automatically receive the prescription drug coverage through CVS Caremark.</td>
<td>You and the university share the cost of coverage. Your portion of the cost is paid with pretax contributions.</td>
</tr>
<tr>
<td>Dental</td>
<td>You can choose from among the available Dental Benefit options or waive coverage. You can choose employee, employee + one, or employee + family coverage. The Dental Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option.</td>
<td>You pay the full cost of coverage with pretax contributions.</td>
</tr>
<tr>
<td>Vision</td>
<td>You can choose from among the available Vision Benefit options or waive coverage. You can choose employee, employee + one, or employee + family coverage. The Vision Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option.</td>
<td>You pay the full cost of coverage with pretax contributions.</td>
</tr>
<tr>
<td>Employee Assistance</td>
<td>You and your Dependents are automatically covered for counseling services.</td>
<td>The university pays the full cost.</td>
</tr>
<tr>
<td>Legal</td>
<td>You can elect to participate in the Legal Benefit in order to protect yourself against high legal fees. You, your Spouse/Domestic or Civil Union Partner, and children will have access to professional attorneys nationwide. With this benefit, certain services are covered at 100%, and you receive a 25% attorney fee discount for other services. Note that you may not cancel your enrollment in this benefit until you have participated for at least 12 months.</td>
<td>You pay the full cost of the coverage with after-tax contributions.</td>
</tr>
<tr>
<td>Benefit Option</td>
<td>Explanation</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Basic Life and AD&amp;D Insurance</strong></td>
<td>You automatically receive Basic Life and AD&amp;D Insurance Benefit coverage equal to one times your benefits salary not to exceed $500,000. The IRS considers the cost of any life coverage exceeding $50,000 “imputed income” that the university will report on your IRS Form W-2 as part of your taxable compensation. Thus, if your benefits salary exceeds $50,000, you may elect to waive Basic Life Insurance Benefit coverage over $50,000. However, if you later decide to change this election, you will need to provide Evidence of Insurability (EOI) at that time. See page 11 for an EOI explanation.</td>
<td>The university pays the full premium for Basic Life and AD&amp;D Insurance Benefits.</td>
</tr>
<tr>
<td><strong>Supplemental Life and/or AD&amp;D Insurance</strong></td>
<td>You can elect optional Supplemental Life and/or AD&amp;D Insurance Benefit coverage in increments of $10,000 up to the lesser of five times your benefits salary or $750,000. You can also waive coverage. If you later decide you want to elect an increased coverage amount, you will need to provide Evidence of Insurability (EOI) at that time. See page 11 for an EOI explanation.</td>
<td>You pay the full premium for any Supplemental Life and/or AD&amp;D Insurance Benefit coverage you elect with after-tax contributions.</td>
</tr>
<tr>
<td><strong>Dependent Life and/or AD&amp;D Insurance</strong></td>
<td>If you elect Supplemental Life and/or AD&amp;D Insurance Benefit coverage, you can elect optional Dependent Life and/or AD&amp;D Insurance Benefit coverage for your Spouse/Domestic or Civil Union Partner and/or eligible Dependent children. You can elect Supplemental Life and/or AD&amp;D Insurance Benefit coverage for your Spouse/Domestic or Civil Union Partner in increments of $5,000 up to the lesser of 50% of your coverage or $375,000. You can elect Supplemental Life and/or AD&amp;D Insurance Benefit coverage for your children (up to age 26) in increments of $2,000 up to the lesser of 50% of your coverage or $10,000, except that supplemental coverage is limited to $1,000 for children up to age six months. You can also waive coverage for your Dependents. If you later decide you want to elect an increased coverage amount for any Dependents, you will need to provide Evidence of Insurability (EOI) for your Dependents at that time. See page 11 for an EOI explanation.</td>
<td>You pay the full premium for any Dependent Life and/or AD&amp;D Insurance Benefit coverage you elect with after-tax contributions.</td>
</tr>
</tbody>
</table>
For Benefits-Eligible Employees
(see Eligibility section on page 8)

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Explanation</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Disability Insurance</td>
<td>If you are a Full-Time Staff Member or Full-Time Faculty Member, then you automatically receive Basic Long-Term Disability Insurance Benefit equal to 60% of your monthly benefits salary, up to $10,000 per month, minus income from other sources. You also have the option to elect a higher level of coverage with the Long-Term Disability Buy-Up Insurance. Pre-existing condition exclusions apply in the first 12 months after your effective date of coverage and are detailed in the Benefit Description.</td>
<td>The university pays the full cost of Basic Long-Term Disability Insurance Benefit coverage, and you pay the full cost of the Long-Term Disability Buy-Up Insurance with after-tax contributions.</td>
</tr>
<tr>
<td>Short-Term Disability Insurance</td>
<td>Part-Time Faculty and Staff Members, and Full-Time Faculty Members with less than two years of benefit-eligible service* who elect Voluntary Short-Term Disability Insurance and who are unable to work because of a non-occupational disability may receive income replacement equal to 60% of their monthly benefits salary up to $3,000 per week for up to 22 weeks after satisfying the 30-day elimination period. Once you become eligible for GW paid short-term disability payments, your coverage in the Voluntary Short-Term Disability Insurance will end and your premiums will stop.</td>
<td>You pay the full cost of your Voluntary Short-Term Disability Insurance with after-tax contributions.</td>
</tr>
</tbody>
</table>

* Benefit-eligible service means you are in a benefit eligible position.

Your Contributions

Your contributions for medical, dental, and vision benefits are made with pretax dollars. That is, they are deducted from your pay before any federal income tax, FICA (Social Security) tax, and Medicare Insurance tax are withheld. Pretax contributions lower the amount of your taxable income and, therefore, lower the taxes you pay.

There are exceptions to the pretax status of your contributions for Non-Qualified Tax Dependents, which are Dependents who do not meet the federal income tax definition. This is explained in more detail below.

Your contributions toward Supplemental Life and/or AD&D Insurance, Dependent Life and/or AD&D Insurance, Long-Term Disability Buy-Up Insurance, Voluntary Short-Term Disability Insurance and Legal Benefits are made with after-tax contributions. That is, they are deducted from your pay after federal income tax; FICA (Social Security) tax, and Medicare Insurance tax are withheld.

Your contributions will be deducted from each paycheck you receive beginning with the first paycheck after you become eligible and elect coverage. For example, if you are hired on October 20, your benefits are effective November 1 and the first paycheck you receive is November 5, then benefit deductions are taken from your November 5th paycheck to cover you during the first half of the month of November.
**Definition of “Dependent” for Tax Purposes**

The Internal Revenue Code treats the cost of coverage for opposite and same-sex Spouses, common law marriage, and children through marriage as exempt from taxes. For any other covered Dependent, a payment for health benefit coverage is not exempt from tax unless the person is a “qualified tax dependent” as defined in the Internal Revenue Code. Under the definition in section 152 of the Internal Revenue Code, a qualified tax dependent must be:

1. A member of your household who has his or her principal place of residence in your home for the full tax year, except for temporary reasons such as vacation, military service, or education.

2. An individual for whom you furnish over half of the support for the year. In making this calculation, the amount you contribute toward the individual’s support must be compared with the amounts received for support of the individual from all other sources, including any amounts supplied by him or her and his or her earnings from employment and other income.

3. Not claimed by another taxpayer as a “qualifying child” for federal income tax purposes for the current year.

If your Domestic or Civil Union Partner (and his or her children) qualify as Dependents for tax purposes, you must provide the university with an “Affidavit of Tax Qualified Dependents” to gain the benefit of tax-favored benefit coverage. Please note that state tax law does not always follow federal tax law in determining who is a Dependent for tax purposes. You should consult a tax advisor to determine whether you may claim your Domestic or Civil Union Partner and/or his or her children as Dependents for tax purposes before you certify that they are tax qualified Dependents.

**Contributions for Your Non-Qualified Tax Dependents**

If your Domestic or Civil Union Partner (and his or her children) are not your Dependents for tax purposes (“Non-Qualified Tax Dependents”), then your contributions for coverage under the Plan will be deducted from your salary on a pretax basis and the total value of the coverage provided on behalf of your Non-Qualified Tax Dependents under the Plan will be considered taxable income to you. You will not actually receive additional income in your paycheck, but the university will withhold city, state, and federal taxes on this additional “imputed” amount and it will be reported on your IRS Form W-2. The value of the coverage provided to your Non-Qualified Tax Dependents will be based on the cost of the coverage under the Plan, as determined by the university. The chart below provides examples of this.

<table>
<thead>
<tr>
<th>If Non-Qualified Tax Dependents are Covered for Medical Benefits</th>
<th>Premium Paid by Employee (Pretax Contribution)</th>
<th>Imputed Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Employee</td>
<td>Employee contribution for Employee Plus Spouse/Domestic Partner coverage</td>
<td>Cost to the Plan of Employee Only coverage</td>
</tr>
<tr>
<td>• Domestic Partner (including Civil Union Partner)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If Non-Qualified Tax Dependents are Covered for Medical Benefits

<table>
<thead>
<tr>
<th>Who is Covered</th>
<th>Premium Paid by Employee (Pretax Contribution)</th>
<th>Imputed Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Employee&lt;br&gt;• Domestic Partner (including Civil Union Partner)&lt;br&gt;• Employee’s Dependent child(ren)</td>
<td>Employee contribution for Employee Plus Family coverage</td>
<td>Cost to the Plan of Employee Only coverage</td>
</tr>
<tr>
<td>• Employee&lt;br&gt;• Domestic Partner (including Civil Union Partner)&lt;br&gt;• Domestic or Civil Union Partner’s child(ren)</td>
<td>Employee contribution for Employee plus Family coverage</td>
<td>Cost to the Plan of Employee Plus Child(ren) coverage for medical and cost of family coverage for other benefits.</td>
</tr>
<tr>
<td>• Employee&lt;br&gt;• Domestic Partner (including Civil Union Partner)&lt;br&gt;• Employee’s Dependent child(ren)&lt;br&gt;• Domestic or Civil Union Partner’s child(ren)</td>
<td>Employee contribution for Employee plus Family coverage</td>
<td>Cost to the Plan of Employee Plus Child(ren) coverage for medical and cost of family coverage for other benefits.</td>
</tr>
</tbody>
</table>
SECTION 4

COBRA
Your Right to Continue Coverage – COBRA

The Consolidated Omnibus Budget Reconciliation Act (“COBRA”) provides you, your Spouse, and your children the right to continue medical, dental, vision, and employee assistance benefit coverage (collectively referred to as “Health Coverage”) if Health Coverage for you, your Spouse, or your children is lost as a result of a “Qualifying Event” (as described in the chart below). In the case of a Qualifying Event, you and/or your children will be offered continuation of Health Coverage for up to the length of time indicated in the chart below.

Continuation of Health Coverage under COBRA does not apply to coverage provided for a Domestic or Civil Union Partner or their children (a “non-qualified tax dependent” as explained on page 23) . The university, however, permits the continuation of their Health Coverage on the same basis as COBRA.

Under COBRA, Participants (or their Dependents) must elect COBRA coverage within 60 calendar days from the Qualifying Event, or, if later, 60 calendar days after you are provided with a notice of your right to elect COBRA coverage. A Participant (or Dependent) who doesn't choose COBRA coverage within this time period loses the right to elect it.

Participants who elect to continue their Health Coverage have the right to add Dependents to their Health Coverage under the same terms applicable to active Benefits-Eligible Employees, e.g., open enrollment and qualifying life events. Children born to, adopted by, or placed with a qualified beneficiary during the COBRA period qualify for coverage under COBRA for the remainder of the qualified beneficiary’s COBRA period.

<table>
<thead>
<tr>
<th>COBRA Qualifying Event</th>
<th>COBRA Maximum Coverage Duration (Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of employment (for any reason other than gross misconduct)</td>
<td>18 months (Benefits-Eligible Employee and covered Dependents); may be extended to 29 months if a qualified beneficiary is disabled*</td>
</tr>
<tr>
<td>Reduction in the Benefits-Eligible Employee’s hours worked</td>
<td>18 months (Benefits-Eligible Employee and covered Dependents); may be extended to 29 months if a qualified beneficiary is disabled*</td>
</tr>
<tr>
<td>Death of the Benefits-Eligible Employee</td>
<td>36 months (covered Dependents)</td>
</tr>
<tr>
<td>Divorce, legal separation, dissolution of a common law marriage, or dissolution of a Domestic or Civil Union Partnership</td>
<td>36 months (Spouse/former Spouse/Domestic Partner/common law spouse/Civil Union Partner and covered Dependent children)</td>
</tr>
<tr>
<td>Dependent child ceases to qualify as a Dependent</td>
<td>36 months</td>
</tr>
</tbody>
</table>

*To be eligible for the 11-month extension, the disabled qualified beneficiary must have been determined to have been disabled during the first 60 calendar days of COBRA coverage and written notice of such determination must be provided to the Benefits Administration Department or PayFlex within 60 calendar days of the date of the determination and before the original 18-month COBRA period expires.
The university contracts with PayFlex to handle COBRA administration, billing, and premium collection. An application for continued benefits under COBRA must be returned directly to PayFlex at the address listed in Section 8: Service Provider Directory. You and/or your Dependents may elect to continue coverage under the Health Coverage in which you and/or they were enrolled at the time the COBRA Qualifying Event occurred. You must make your election within 60 calendar days of the COBRA event or receipt of the COBRA notice, whichever is later.

Each month, you and/or your Dependents will receive a bill for the full premium with instructions for submitting payment. The cost of the coverage will be 102% of the applicable premium for any period of continued coverage. The first premium must be paid within 45 calendar days of the individual’s election to continue coverage, and must cover the number of full months from the date the coverage was lost until the date the first premium for coverage under COBRA is received. Subsequent premiums are due on the first of each month for that month, subject to a 30-day grace period. In most cases, medical, dental, vision and/or employee assistance benefit coverage begins on the first day after the day your coverage would otherwise have been terminated to prevent a lapse in coverage.

If you elect to continue coverage following a termination of employment or a reduction in hours and, during the 18-month period of continuation coverage, a second event occurs that would have caused your Dependents to lose coverage under the Plan (if they had not lost coverage already), then they may be given the opportunity to extend the period of continuation coverage up to a total of 36 months. You or your Dependents must notify PayFlex in writing at the address listed in Section 8, of the occurrence of the second event. In addition, if you (the covered Benefits-Eligible Employee) become entitled to Medicare, special rules may apply. Contact the Benefit Administration Department for more information.

Coverage will end before the maximum duration period for any of the following reasons:

- Failure to pay the applicable premium by the due date;
- Anyone who has made an election to receive COBRA coverage and who later becomes covered under any other group health plan that does not contain any exclusions or limitations with respect to a pre-existing condition of the individual, other than a pre-existing condition or exclusion that does not apply to or is satisfied by the individual under applicable federal law;
- Anyone who has made an election to receive COBRA coverage and who later becomes entitled to Medicare benefits;
- The individual is no longer disabled during the 11-month extension of benefits for disability; or
- The university ceases to provide Health Coverage to any Benefits-Eligible Employee.

**Where You Can Learn More**

You can contact the call center at (888) 4GWUBEN (449-8326) or the Benefit Administration Department at (703) 726-8382 or [http://benefits.gwu.edu](http://benefits.gwu.edu) for additional information on COBRA.
SECTION 5

Special Situations Affecting Your Benefits
Special Situations Affecting Your Benefits

Change in Employment Status

If you do not currently satisfy the definition of “Benefits-Eligible Employee” but the university later reclassifies you as a Benefits-Eligible Employee or you are in a non-benefits eligible position and later become eligible for benefits, you will be eligible to participate in the Plan on the first of the month following such reclassification if you satisfy the eligibility requirements of a Benefit Option and you enroll in accordance with the applicable provisions of the Benefit Option.

If you or the university change your employment status to a position that makes you ineligible for a benefit, your coverage under the Medical, Dental, Vision, and Employee Assistance Benefits will continue until the last day of the month in which your employment status changes, but your Life and AD&D Insurance, Long-Term Disability Insurance, and Short-Term Disability Insurance Benefit coverage will cease as of the date you no longer satisfy the applicable eligibility requirements. Your Legal Benefit will terminate at midnight on the last day of the month following your last day of eligibility.

If You Are On a Leave of Absence

The following paragraphs set forth the general rules regarding how typical paid and unpaid leaves of absence affect your benefits. To learn how these rules apply in special circumstances (such as receipt of worker’s compensation or sabbaticals), you should go to “Benefits Administration” on the university’s website at http://benefits.gwu.edu and click on to the “Leave” link.

Unpaid Leave of Absence

If you are on approved unpaid leave of absence that is not FMLA Leave or Qualified Military Leave (see below) during the Plan year, you can choose to continue your participation in the Medical, Dental, Vision, Employee Assistance, and Legal Benefits through the duration of your leave of absence, provided your premiums are paid on time. Your Basic and Supplemental Life and/or AD&D Insurance Benefit coverage as well as your Voluntary Short-Term and Long-Term Disability Insurance Benefit coverage will continue through the duration of your unpaid leave of absence; but they will only continue until the last day of the month following the month in which your leave of absence begins.

If your unpaid leave of absence is 30 calendar days or less, your portion of the cost for benefits will go into arrears and be deducted from your pay upon your return to work. If your unpaid leave of absence exceeds 30 calendar days and you elect to continue your benefits, you will be responsible for remitting your share of the cost of the benefits directly to GW. If you elect to continue Vision and Dental Benefit coverage, you are responsible for continuing to pay your cost of coverage.

You may cancel your benefits within 30 calendar days of the start of your unpaid leave of absence through EasyEnroll at www.benedetails.gwu.edu. Upon your return to active employment, you may re-enroll or make a change to your benefits consistent with a qualifying life event within 30 calendar days of returning to work through EasyEnroll. You should also refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights.
Unpaid Leave of Absence – FMLA and Qualified Military Leaves

If you are on approved FMLA Leave or Qualified Military Leave, you may elect to continue your Medical, Dental, Vision, Employee Assistance, Legal, Basic Life and AD&D Insurance, Supplemental Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage through the duration of your leave of absence.

If your unpaid FMLA Leave or Qualified Military Leave is 30 calendar days or less, your portion of the cost for benefits will go into arrears and be deducted from your pay upon your return to work. If your unpaid leave of absence exceeds 30 calendar days and you elect to continue your benefits, you will be responsible for remitting your share of the cost of the benefits directly to the university. **Note: If you do not return to work following FMLA Leave, you will be required to reimburse the university for the university’s portion of benefit costs paid on your behalf during your FMLA Leave.**

You may cancel your benefits within 30 calendar days of the start of your unpaid leave of absence through EasyEnroll at www.benedetails.gwu.edu. Upon your return to active employment, you may re-enroll or make a change to your benefits consistent with a qualifying life event within 30 calendar days of returning to work through EasyEnroll. You should also refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights.

Paid Leave of Absence

If you are on a paid leave of absence for any reason other than disability (including FMLA Leave), your Medical, Dental, Vision, Life and AD&D, Long-Term Disability Insurance, Short-Term Disability Insurance, Legal, and/or Employee Assistance Benefits, and your contributions, continue as though you were in active employment status.

**Note:** If you are on FMLA Leave, your leave of absence may be paid, unpaid, or a combination of paid and unpaid depending on your accumulated paid time off balances. (Refer to the university’s Family and Medical Leave Policy.)

Disability Leave of Absence

If you qualify for short-term disability, you may elect to continue your Medical, Dental, Vision, Supplemental Life and/or AD&D Insurance, Voluntary Short-Term Disability Insurance, Long-Term Disability Buy-Up Insurance, and Legal Benefit coverage as long as you continue to pay your share of the cost for such coverage. Your Basic Life and AD&D Insurance, Basic Long-Term Disability Insurance and Employee Assistance Benefit automatically continue during a short-term disability.

If you qualify for long-term disability benefits, please refer to the Benefit Descriptions for specific information about the impact to the Benefit Options in which you are currently enrolled. **In order to elect eligible Benefit Options, you must notify the university in writing of the benefits you wish to elect within 30 calendar days after the start of your approved long-term disability benefit.** If you were covered under the Medical Benefit for active employees on the date your long-term disability benefit is approved, then you have the option to elect for yourself and your Eligible Dependents a similar, but separate, Medical Benefit at premium rates for long-term disability participants. If you have Dental and Vision Benefit coverage when you qualify for long-term disability benefits, you pay the same cost as active employees if you elect the coverage.
Your coverage under the Basic and Supplemental Life and/or AD&D Insurance Benefits may also continue through the period of your long-term disability. The university will continue to pay the premium for your Basic Life and AD&D Insurance Benefits. You will be responsible for paying the premiums for any Supplemental Life and/or AD&D Insurance Benefits you elect for yourself and your Dependents. Please refer to your Benefit Descriptions for more information about applying for the waiver of any Basic and Supplemental Life Insurance Benefit premiums after satisfying the applicable conditions.

You may also continue your coverage under the Short-Term and Long-Term Disability Insurance Benefits through the duration of your leave of absence as long as your employment has not terminated. If you elected the Long-Term Disability Buy-Up Insurance, your premium will be waived once your long-term disability benefit has been approved.

Finally, you may elect to continue your coverage under the Legal Benefit through the duration of your long-term disability leave of absence as long as you continue to pay the premium for the coverage.

Please keep in mind that the university reserves the right to change this cost-sharing structure in the future or to eliminate coverage entirely.

**If you are considering a settlement with the Long-Term Disability Insurance carrier, your eligibility for certain benefits may be impacted. Contact the Benefits Administration Department for further information on the impact of a settlement on your other benefits.**

**If You Return from a Leave of Absence**

If your benefit coverage ends or you are not eligible for coverage during a leave of absence, you must take action to re-enroll in your Benefit Options within 30 calendar days of your return to work, or wait for next open enrollment to re-enroll. You will not be automatically re-enrolled.

**If You Retire**

If you retire, coverage under this Plan for you and your Dependents will end. However, you may be eligible to continue Health Coverage through COBRA as described in Section 4 above. In addition, if you meet the eligibility requirements of the Health and Welfare Plan for Retired Employees then you and your Dependents may have the opportunity to elect coverage as provided in the Health and Welfare Plan for Retired Employees.

**IMPORTANT: All determinations as to your eligibility for retiree coverage will be made in accordance with the university’s Health and Welfare Plan for Retired Employees.**

**If You Are Re-employed**

If you are retired and eligible for benefits under the university's Health and Welfare Plan for Retired Employees, then that coverage will cease if you are re-employed by the university and you will again be eligible for coverage under this Plan. You will be required to contribute to your coverage under the same guidelines as an active employee with the same job title.

If you are enrolled in Medicare Parts A and B, you also need to contact Medicare to inform them of your return to active employment.
SECTION 6

Administrative Information
Introduction to Administrative Information

This information describes your rights as a Plan Participant, the procedure to appeal a claim denial, and administrative information to assist you with questions, complaints, or problems concerning a Benefit Option.

If you have any questions concerning your benefits, you can call or write:

The Benefits Administration Department
The George Washington University
45155 Research Place, Suite 160
Ashburn, VA 20147
(703) 726-8382

Plan Sponsor and Administration

The university sponsors The George Washington University Health and Welfare Benefit Plan. The Plan Administrator for The George Washington University Health and Welfare Benefit Plan is:

Plan Administration Committee
The George Washington University
45155 Research Place, Suite 160
Ashburn, VA 20147
(703) 726-8324

The university sponsors and administers each of the Benefit Options described in this SPD except to the extent that it has entered into a contract with an insurer or other organization to provide benefits. In that case, the insurer or other organization assists the university in certain areas of Plan administration, such as processing claims for benefits and paying benefits.

If you have any questions about your benefits, contact the Benefits Administration Department first. If the Benefits Administration Department cannot immediately answer your question, someone will get back to you with the answer or the name of the person, department, or agency that can provide you with the information you need.

Plan Identification

When dealing with or referring to benefits for claims, appeals, or other correspondence, you will receive help more quickly if you identify them fully and accurately.

To identify correspondence with the federal government related to the Plan, you need to use the university’s Employer Identification Number (EIN), which is assigned by the Internal Revenue Service. The university’s EIN is 53-0196584. You also need to know the Plan’s official name, which is The George Washington University Health and Welfare Benefit Plan, and Plan identification number, which is 501.
Plan Year

The records for each Benefit Option of this Plan are maintained on a twelve-month basis. The Plan year is the same as the calendar year: it begins on January 1 and ends on December 31.

Agent for Service of Legal Process

The agent on whom legal process for a lawsuit should be served is:

Mary Lynn Reed
Senior Counsel
The George Washington University
2100 Pennsylvania Avenue, NW, Suite 250
Washington, DC 20052

Not a Contract of Employment

No provisions of any of the Benefit Options are considered a contract of employment between you and the university, nor does your participation in any benefit provide any guarantee of continued employment. The university’s rights with regard to disciplinary action and termination of any Benefits-Eligible Employee, if necessary, are in no manner changed by any provision of any Benefit Option.

Plan Continuation

The university (acting through the Executive Vice President and Treasurer) reserves the right to amend, suspend, change, or terminate the Plan or any Benefit Option (or any portion thereof) at any time and for any reason. This means that any benefit provided through the Plan, a Benefit Option, or any portion thereof may be discontinued in its entirety, modified to provide higher or lower levels of covered benefits, or modified to provide higher or lower levels of cost to the university or to Participants. If the Plan, a Benefit Option, or any portion thereof is terminated or amended in a material fashion, you will be notified promptly if you are affected by the termination or amendment. In no event will any termination or amendment of the Plan, a Benefit Option, or any portion thereof adversely affect the payment of benefits to which you already were entitled to under the terms of the Plan or the Benefit Option immediately prior to the amendment or termination.

Plan Funding

Certain Benefit Options described in this SPD are paid or provided by the university from the university’s general assets; other Benefit Options are insured and provided under insurance contracts. See Section 8 for more information.
Your Rights as a Plan Participant

As a Participant in The George Washington University Health and Welfare Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue Health Coverage for yourself and/or for your Dependents if there is a loss of Health Coverage under the Plan as a result of a Qualifying Event. You and/or your Dependents may have to pay for such coverage. Review this SPD and the other documents governing the Plan for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your coverage enrollment date.

Prudent Actions by Plan Fiduciaries

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 calendar days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Benefits Administration Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Authority of Plan Administrator

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator’s delegates, these service providers have the discretionary authority to make decisions under the Plan relating to benefit claims, including interpreting Plan terms, resolving disputed issues of fact, and making determinations as to the medical necessity of any service or supply.
The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, interpretations, and disputed issues of fact) will be final and binding on all parties.

**Decisions on Health Coverage**

Health Coverage provides solely for the payment of certain healthcare expenses. All decisions regarding healthcare are the sole responsibility of each covered individual in consultation with the healthcare providers selected by the individual. The Plan contains rules for determining the percentage of allowable healthcare expenses that will be reimbursed and whether particular treatments or healthcare expenses are eligible for reimbursement. The covered individual in accordance with the Plan’s claims procedure may dispute any decision with respect to the level of healthcare reimbursement, or the coverage of a particular healthcare expense. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the university shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of Health Coverage.

**Qualified Medical Child Support Order (“QMCSO”)**

A QMCSO is a court order giving a child who otherwise might not be eligible for coverage under the Plan, a right to such coverage. Normally, the court in connection with a divorce or separation, issues such an order. Before the Plan Administrator complies with a QMCSO, it must determine that the court order meets the requirements of applicable law pertaining to QMCSOs. You will be notified, if the Plan Administrator receives a court order relating to you and of the procedure used by the Plan Administrator to determine whether the order is a QMCSO. Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

**Privacy of Health Information**

The receipt, use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as “HIPAA”). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan’s business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and healthcare operations under the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. See Appendix A for more information.
Medical Benefit Notices

Pre-existing Conditions

The Medical Benefit covers pre-existing conditions from the date coverage becomes effective for you and your Dependents.

Hospital Stays for Maternity

The Medical Benefit allows for a minimum stay of 48 hours after the vaginal delivery of a newborn and 96 hours after a cesarean section, in accordance with federal laws. Providers are not required to obtain authorization from the university or UnitedHealthcare for prescribing a length of stay not in excess of these periods.

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

Women’s Health and Cancer Rights Act Notice

The Women’s Health and Cancer Rights Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prostheses and physical complications in all stages of mastectomy, including lymphedemas.

These services shall be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services is subject to all applicable deductibles and coinsurance amounts.

Medicaid and the Children’s Health Insurance Program (CHIP)

If you are eligible for health coverage from the university, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. You can contact 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Health Insurance Marketplace

The Health Insurance Marketplace (“Marketplace”) is available after 2014 to buy health
insurance. The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. If you are not eligible for health coverage from the university (or in a family member’s employer-sponsored plan), or you are eligible but the coverage does not meet certain standards, then you may qualify to lower your monthly premium in the Marketplace. The amount of savings on your premium, if any, depends on your household income. If you are eligible for health coverage from the university and choose to purchase a health plan through the Marketplace instead, then you may lose the university’s contribution towards the university-offered coverage. You can obtain more information about the Marketplace at www.HealthCare.gov.

Third-Party Recovery/Subrogation

General Principle

When you or your Dependent receive benefits under the Plan which are related to medical expenses that are also payable under workers’ compensation, any statute, any uninsured or underinsured motorist program, any no-fault or school insurance program, any other insurance policy, or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement, or for any other reason, you or your Dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your Dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your Dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your Dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan’s share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan’s right to subrogation or reimbursement will not be affected or reduced by the “make whole” doctrine, the “fund” doctrine, the “common fund” doctrine, comparative/contributory negligence, “collateral source” rule, “attorney’s fund” doctrine, regulatory diligence or any other equitable defenses that may affect the Plan’s right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your Dependent to assert a claim to any of the benefits to which you or your Dependent may be entitled. The Plan will not pay attorney’s fees or costs associated with the claim or lawsuit without express written authorization from the university.

If the Plan should become aware that you or your Dependent has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your Dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your Dependents.
**Participant Duties and Actions**

By participating in the Plan you and your Dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your Dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your Dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your Dependent must notify the Plan. And, at that time, you and your Dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan’s subrogation rights and the Plan’s right to be reimbursed for expenses arising from circumstances that entitle you or your Dependent to any payment, amount or recovery from a third party.

If you or your Dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your Dependents until the agreement is signed. Alternatively, if you or your Dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your Dependent, your or your Dependent’s acceptance of such benefits shall constitute agreement to the Plan’s right to subrogation or reimbursement.

You and your Dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan’s consent. As such, the Plan’s reimbursement will not be reduced by attorneys’ fees and expenses without express written authorization from the university.

**Recoupment**

The Plan has the right to recover any mistaken payment, overpayment, or any payment that is made to any individual who was not eligible for that payment. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.
**Benefit Payments to Third Parties**

The Plan Administrator may elect to pay benefits directly to a healthcare provider unless the payment has already been made by the covered person. Where the healthcare provider rendering services does not have an agreement with the Plan to the contrary, the Plan Administrator may, at its election, pay benefits directly to the covered person. In the event the covered individual is deceased, benefits may be paid at the Plan Administrator’s option to the covered person’s estate, Spouse (including a same-sex or opposite-sex spouse, common law spouse), or Domestic or Civil Union Partner, the participant through whom the individual is covered, or the covered person’s closest relative as determined by the Plan Administrator.

**No Assignment of Benefits**

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a healthcare provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

**Claims Information**

This section gives you information about filing claims and what to do if a claim is denied. To receive a Benefit Option, you must file a claim. The following provides information on filing claims for Benefit Options. For addresses and phone numbers please refer to Section 8. In most cases addresses are also listed on the claim form.

**Filing a Claim**

Claims for Benefit Options should be made to the service provider identified in Section 8 for each benefit in accordance with the instructions provided in the Benefit Description or other descriptive materials provided for such benefit.

A request for a Benefit Option is a “claim” only if it is filed by a Plan Participant or beneficiary or his or her authorized representative in accordance with the applicable claims procedures. In general, claims must be filed in writing with the appropriate claims administrator. A request for prior approval of a benefit or service where prior approval is not required under the Benefit Option is not a “claim” under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a “claim” under these rules, unless it is determined by the claims administrator that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the claims administrator to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the claims administrator identifying such authorized representative.
Claims and Appeals Procedures

The applicable Benefit Description that describes a particular benefit under the Plan will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. The claims procedures in such Benefit Description shall be interpreted to comply with (a) section 503 of ERISA, (b) 29 C.F.R. § 2560.503-1 (the Department of Labor claims procedure regulation), and (c) 29 C.F.R. § 2590.715-2719. If no appeals procedures are provided in a Benefit Description, then the procedures below will apply.

Decision On A Claim

If a claim for benefits is denied in full or in part, the claims administrator will notify you in writing within 90 calendar days after it receives the written claim. This time limit may be extended for another 90 calendar days in special cases, if the claims administrator provides notice of the reasons for the delay.

Urgent Care Claims

An “urgent care claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health, or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that can’t be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply, or procedure before a benefit is payable, and if the claims administrator or your physician determines that it’s an urgent care claim, you’ll be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there’s not sufficient information to decide the claim, you’ll be notified what information is necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You’ll be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you’ll be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply, or procedure before a benefit is payable, a request for advance approval is considered a pre-service claim. You’ll be notified of the decision not later than 15 calendar days after receipt of the pre-service claim.

For other claims (post-service claims), you’ll be notified of the decision no later than 30 calendar days after receipt of the claim.

For either a pre-service claim or a post-service claim, these time periods may be extended up to an additional 15 calendar days due to circumstances outside the claims administrator’s control. In that case, you’ll be notified of the extension before the end of the initial 15- or 30-day period. For example, the time period may be extended because you haven’t submitted sufficient information,
in which case you’ll be notified of the specific information necessary and given an additional period of at least 45 calendar days after receiving the notice to furnish that information. You’ll be notified of the claim decision no later than 15 calendar days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a representative of the claims administrator but which otherwise fail to follow the Plan’s procedures for filing pre-service claims, you’ll be notified of the failure within five calendar days (within 24 hours in the case of an urgent care claim) and of the proper procedures to follow. The notice may be oral unless you request written notification.

**Ongoing Course of Treatment**
If you have received pre-authorization for an ongoing course of treatment, you’ll be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you’ll have an opportunity to appeal any decision to the claims administrator and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care and you request an extension of the course of treatment at least 24 hours before its expiration, you’ll be notified of the decision within 24 hours after receipt of the request.

**Notice of Claim Denial**
The notice of denial (written or electronic) will include the reasons for the denial, the specific Plan provisions on which the denial is based, a description of any additional information or material required if you want to appeal the denial, the procedure and time limits for filing an appeal so that the claims administrator will reconsider its decision, and a statement of the right to sue under Section 502(a) of ERISA in court if the claim is again denied after an appeal.

**Appeal Procedure**
If a claim is denied, you may write to the claims administrator for a review of the claim on appeal. The claimant must request the review on appeal in writing within 60 calendar days after the claim is denied. A claimant who fails to submit an appeal request within the 60-day period will have no further right to appeal.

As part of the appeal review procedure, you will be allowed to:
- submit additional documents, records, and information relating to the claim;
- request in writing access to and copies (free of charge) of all Plan documents, records and other information affecting the claim;
- appeal the denial in writing; and
- have someone act as your representative in the appeal procedure.

**Standard Appeals**
You have the right to file an appeal from an adverse benefit determination relating to service(s) you have received or could have received from your healthcare provider under the Plan.

An “adverse benefit determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply, or benefit. Such adverse
benefit determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there’s an adverse effect on any particular benefit);

- Coverage determinations, including Plan limitations or exclusions;

- The results of any utilization review activities;

- A decision that the service or supply is experimental or investigational; or

- A decision that the service or supply isn’t medically necessary.

A “final internal adverse benefit determination” is defined as an adverse benefit determination that has been upheld by the appropriate named fiduciary at the completion of the internal appeals process, or an adverse benefit determination for which the internal appeals process has been exhausted.

**Exhaustion of Internal Appeals Process**

Generally, you’re required to complete all appeal processes of the Plan before being able to obtain external review or bring an action in litigation. However, if the claims administrator, or the Plan or its designee, doesn’t comply with all claim determination and appeal requirements under applicable federal law, except if such failure is a *de minimis* violation that doesn’t cause, and is not likely to cause, you prejudice or harm, then you’re considered to have exhausted the Plan’s appeal requirements (“deemed exhaustion”) and may proceed with external review or may pursue any available remedies under Section 502(a) of ERISA or under state law, as applicable.

**Full and Fair Review of Claim Determinations and Appeals**

The claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the service provider), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to the service provider at the address provided in Section 8, or, if your appeal is of an urgent nature, you may call the service provider at the toll-free phone number listed in Service Provider Directory. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records, and other information you would like to have considered, whether or not submitted in connection with the initial claim.

A representative of the service provider and/or the claims administrator may call you or your medical provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You’ll have 180 calendar days following receipt of an adverse benefit determination to appeal the determination to the claims administrator. You’ll be notified of the decision no later than 15
calendar days (for pre-service claims) or 30 calendar days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the claims administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to the service provider. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the claims administrator by telephone, facsimile, or other similar method. You’ll be notified of the decision no later than 72 hours after the appeal is received.

If you’re dissatisfied with the appeal decision on an urgent care claim, you may file a second-level appeal with the claims administrator. You’ll be notified of the decision no later than 36 hours after the appeal is received.

If you’re dissatisfied with a pre-service or post-service appeal decision, you may file a second-level appeal with the claims administrator within 60 calendar days of receipt of the level-one appeal decision. The claims administrator will notify you of the decision no later than 15 calendar days (for pre-service claims) or 30 calendar days (for post-service claims) after the appeal is received.

If you don’t agree with the final internal adverse benefit determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Medical Claims – Voluntary External Appeals
Special rules apply to certain claims for medical benefits (including vision benefits and prescription drug benefits) under the Plan.

External Review
“External review” is a review of an adverse benefit determination or a final internal adverse benefit determination by an independent review organization/external review organization (ERO) or by the state insurance commissioner, if applicable.

A “final external review decision” is a determination by an ERO at the conclusion of an external review.

You must complete the first level of standard appeal described under “Standard Appeals” before you can request external review, other than in a case of “deemed exhaustion.” Subject to verification procedures that the Benefit Option may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for external review of any adverse benefit determination or any final internal adverse benefit determination that qualifies as set forth below.
The notice of adverse benefit determination or final internal adverse benefit determination that you receive from the claims administrator will describe the process to follow if you wish to pursue an external review, and will include a copy of the request for external review form.

You must submit the request for external review form to the claims administrator within 4 months of the date you received the adverse benefit determination or final internal adverse benefit determination notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that isn’t a Saturday, Sunday, or a federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will count while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the medical coverage option. However, the appeal is voluntary and you’re not required to undertake it before pursuing legal action.

If you choose not to file for voluntary external review, then you must file for a second level of standard appeals as described under “Standard Appeals” to exhaust your administrative remedies under the Plan.

**Request for External Review**

The external review process for the medical coverage options gives you the opportunity to receive review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to applicable law. Your request will be eligible for external review if the following are satisfied:

- The claims administrator, or the Plan or its designee, doesn’t comply with all claim determination and appeal requirements under applicable federal law, except if such failure is a *de minimis* violation that doesn’t cause, and is not likely to cause, you prejudice or harm; or
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage that has retroactive effect.

External review is only available if your claim involves medical judgment or a rescission of coverage. An adverse benefit determination based upon your eligibility isn’t eligible for external review. External review is not available for claims under the Dental Benefit.

If upon the first standard level of appeal, the coverage denial is upheld and it’s determined that you’re eligible for external review, you’ll be informed in writing of the steps necessary to request an external review, as well as additional internal review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question.

**Preliminary Review**

Within five business days following the date of receipt of the request, the claims administrator
must provide a preliminary review determining whether you were covered under the medical coverage option at the time the service was requested or provided, that the determination doesn’t relate to eligibility, that you have exhausted the internal appeals process (unless “deemed exhaustion” applies), and that you have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, the claims administrator must issue to you a notification in writing. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number: 866-444-EBSA (3272)). If the request isn’t complete, such notification will describe the information or materials needed to make the request complete and the claims administrator must allow you to perfect the request for external review within the 4-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

**Referral to an External Review Organization (ERO)**

The claims administrator will assign an accredited ERO, as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of the request’s eligibility and acceptance for external review, and will provide an opportunity for you to submit in writing, within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the external review. Within one business day after making the decision, the ERO must notify you, the claims administrator, and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending medical professional’s recommendation;
- Reports from appropriate medical professionals and other documents submitted by the Plan or service provider, you, or your treating provider;
- The terms of your Plan to ensure that the ERO’s decision isn’t contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO’s clinical reviewer or reviewers after considering the information
described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the final external review decision within 45 calendar days after the ERO receives the request for the external review. The ERO must deliver the notice of final external review decision to you, the claims administrator, and the Plan.

After a final external review decision, the ERO must maintain records of all claims and notices with the external review process for six years. An ERO must make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**Expedited External Review**
The Plan must allow you to request an expedited external review at the time you receive:

- An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or medical item or service for which you received emergency services, but haven’t been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The claims administrator must immediately send you a notice of its eligibility determination.

**Referral of Expedited Review to an External Review Organization (ERO)**
Upon a determination that a request is eligible for external review following preliminary review, the claims administrator will assign an ERO. The ERO will render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice isn’t in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, the claims administrator, and the Plan.

**Time Limit on Legal Proceedings**
After exhausting the Plan's administrative claim process described above, a claimant may file a
lawsuit regarding entitlement to benefits. Any such legal action must be commenced within one
year from the time that a benefit claim appeal is denied (unless otherwise prescribed by applicable
law).
SECTION 7

Glossary
• **Benefit Description** – A benefit booklet, group insurance policy, insurance contract, certificate of coverage, or other document specifying the terms, conditions, exclusions, and other rules for a Benefit Option provided pursuant to this Plan.

• **Benefits Salary** - Your benefits salary is equal to the salary(ies) of your active benefit eligible primary and secondary positions. This Benefits Salary is used to determine salary driven contributions as well as plan coverages and premiums, as applicable. For purposes of calculating your Short Term Disability Insurance Benefit, Long Term Disability Insurance Benefit, Life and AD&D Insurance Benefit, your Benefits Salary is your gross bi-weekly/monthly income from all benefits eligible positions from the university in effective just prior to your date of disability, injury or death. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, non-benefits eligible compensation, any other extra compensation, or income received from sources other the university.

• **Benefits Administration Department** – The office located on the Virginia Science and Technology Campus where your benefits under this Plan are serviced with the assistance of service providers. The contact information is: 45155 Research Place, Suite 160, Ashburn, VA 20147, Ph: (888) 4GWUBEN (449-8236), Fax: 703-726-8385, email: benefits@gwu.edu, website: [http://benefits.gwu.edu](http://benefits.gwu.edu).

• **Benefits-Eligible Employee** – Any individual on the payroll of the university, and not paid by accounts payable, whose wages from the university are subject to withholding for the purposes of federal income taxes and the Federal Insurance Contributions Act. The term Benefits-Eligible Employee shall not include:

  o a student, including a fellow, graduate teaching assistant or other person whose employment is incidental to his or her educational program, as determined by the university;

  o a Faculty Member who is appointed on a temporary basis as a part-time lecturer or professorial lecturer of one-semester (or less) or paid on a per-course basis;

  o a member of a collective bargaining unit unless such member is covered by a collective bargaining agreement that expressly provides for participation in the Plan;

  o a nonresident alien with no U.S. source earned income (as that term is described in Code section 410(b)(3)(C));

  o a leased employee;

  o an individual whom the university classifies as a temporary employee, independent contractor, contract worker, casual employee, or consultant (regardless of the individual’s employment status under applicable law);

  o any person who is regularly scheduled to work less than 14 hours per week; or
any person excluded from participation under the terms of the Benefit Descriptions.

- **Benefit Options** – The various health and welfare benefits provided or made available to Participants by the university as set forth herein and incorporated hereunder.

- **CHIP** – The Children’s Health Insurance Program.

- **Civil Union Partner**– A partner of a Participant who has legally entered into a Civil Union pursuant to the applicable state’s law.


- **Dental Benefit** – The dental insurance benefit provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

- **Dependent** – Unless otherwise specified in the Plan or the applicable Benefit Description, the term Dependent shall include:
  
  - the legal Spouse (as defined by federal law) of the Participant, the common law Spouse of the Participant, the Domestic Partner or Civil Union Partner of the Participant;
  
  - a Participant’s child (including stepchildren, children legally placed for adoption, legally adopted children, and children of a same-sex Domestic or Civil Union Partner) if such child is under age 26; and
  
  - a Participant’s child who is age 26 or older if such child is a “qualifying child” as defined in Section 152 of the Code and regulations promulgated thereunder.

  The Plan may require Participants to submit proof of continued eligibility for covered Dependents. A Participant’s failure to provide such information upon request shall be deemed a loss of such Dependent status and will result in the immediate termination of the Dependent’s coverage hereunder. The term Dependent may also include additional conditions as provided under this Plan or the Benefit Description applicable to a particular Benefit Option.

- **Domestic Partner** – The partner of a Participant where the Participant and the Domestic Partner are registered Domestic Partners or meet the requirements on the Declaration of Domestic Partnership (including, but not limited to, are unmarried and unrelated, share a common residence, and have been emotionally and financially interdependent for at least the past six months). The Participant and the Domestic Partner must complete a Declaration of Domestic Partnership for the partner to be considered a Dependent under the Plan. The term Domestic Partner may also include additional conditions as defined under the particular Benefit Descriptions.

- **Employee Assistance Benefit** – The counseling services benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

• **Evidence of Insurability (EOI)** – Proof showing you and/or your Dependents are in good health.

• **Faculty Member** –
  - **Full-Time Faculty Member** – A Benefits-Eligible Employee who is appointed for at least one academic year in one of the regular, visiting, special service, or research ranks listed in the Faculty Code, who devotes 100% effort, and who receives full salary through the university. Faculty appointed on a temporary basis (one semester or less) are not included. Full-Time Faculty Member also includes a Partial Retiree as provided in the Faculty Code, which is a Benefits-Eligible Employee who is a Full-Time Faculty Member who reduces their workload to either a two-thirds or a half-time basis. Such Partial Retiree will continue to be eligible for benefits as a Full-Time Faculty Member during the partial retirement period.
  - **Part-Time Faculty Member** – A Benefits-Eligible Employee who is appointed for at least an academic year, who devotes at least one-third time to university duties, and is compensated at no less than one-third of a full-time equivalent salary for that period. Part-time faculty who are on one-semester appointments or who are compensated on a per-course basis are not included.

• **FMLA Leave** – An authorized leave of absence that is taken pursuant to the Family and Medical Leave Act of 1993, as amended.

• **Health Coverage** – Medical, Dental, Vision, and Employee Assistance Benefits that are protected by COBRA.

• **Health and Welfare Plan for Retired Employees** – The George Washington University Health and Welfare Plan for Retired Employees maintained by the university, as it may be amended from time to time.

• **HIPAA** – The Health Insurance Portability and Accountability Act of 1996, as amended.

• **Legal Benefit** – The legal services benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

• **Life and AD&D Insurance Benefit** – The life insurance and accidental death and dismemberment insurance coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

• **Long-Term Disability Insurance Benefit** – The long-term disability insurance coverage provided or made available to eligible Participants, as it may exist from time to time.

• **Medical Benefit** – The medical and prescription drug benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.
• **Participant** – A Benefits-Eligible Employee who becomes a Participant pursuant to Section 2.

• **Plan** – The George Washington University Health and Welfare Benefit Plan provided for herein, as it may be amended from time to time.

• **Plan Administrator** – The George Washington University Plan Administration Committee.

• **Qualified Military Leave** – An authorized leave of absence that is taken pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

• **QMCSO** – A medical child support order that complies with Section 609 of ERISA and any state laws governing such orders.

• **Resident** – A Benefits-Eligible Employee who serves as a medical resident.

• **Short-Term Disability Insurance Benefit** – The short-term disability coverage provided or made available to eligible Participants, as it may exist from time to time. Also called Voluntary STD.

• **SPD** – Summary Plan Description – this document.

• **Spouse** – The legal Spouse of the Participant (whether opposite-sex or same-sex) as defined by the state in which such Participant married, whether or not the state in which the Participant resides recognizes that marriage; or the common law Spouse of the Participant as defined by the state law in which the Participant resides.

• **Staff Member** – A Benefits-Eligible Employee of the university who is a regular full-time or regular part-time, graded or ungraded employee, who is not classified as a Faculty Member.
  - o **Full-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 40 hours per week.*
  - o **Part-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 14 hours a week but less than 40 hours per week.

• **University** – The George Washington University.

• **Vision Benefit** – The vision insurance benefit provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

* Benefits-Eligible Employees at the GW Biostatistics Center who work 34 or more hours a week are considered Full-Time Staff for purposes of benefits.
SECTION 8

Service Provider Directory
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Provider/Claims Administrator</th>
<th>Contact Information</th>
<th>Group / Identification Number (If Applicable)</th>
<th>Funding *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>UnitedHealthcare</td>
<td>(877) 706-1739 UnitedHealthcare – Claims P.O. Box 740800 Atlanta, GA 30374-0800</td>
<td>Group Number: 730193</td>
<td>Self-Funded</td>
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<tr>
<td>– Choice Plus Buff</td>
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<td>– Choice Plus Blue</td>
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<tr>
<td>– Choice</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prescription Drug</td>
<td>CVS Caremark</td>
<td>(877) 357-4032 CVS Caremark Customer Care Correspondence P.O. Box 832407 Richardson, TX 75083</td>
<td>Group Number: J226001</td>
<td>Self-Funded</td>
</tr>
<tr>
<td>Dental</td>
<td>Aetna</td>
<td>(877) 238-6200 Aetna Dental P.O. Box 14094 Lexington, KY 40512-4094</td>
<td>Group Policy Number: GP-622758</td>
<td>Insured</td>
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<tr>
<td>– High Option PPO</td>
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<td>– Low Option PPO</td>
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<tr>
<td>– Dental Maintenance Organization (DMO)</td>
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* Self-Funded: The university has contracted with the organization to provide administrative and claims administration services under the Plan for the benefit. Benefits are paid entirely by the university from its general assets and not by the organization.

Insured: The university has contracted with the insurance company to provide these benefits under the Plan. Benefits are paid entirely by the insurance company in accordance with the terms of the Plan and the policy. All claims decisions are made by the insurance company.
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<tr>
<th>Benefit</th>
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<th>Funding *</th>
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<tr>
<td>Vision</td>
<td>UnitedHealthcare</td>
<td>Customer Service: (800) 638-3120&lt;br&gt;Provider Locator: (800) 839-3242&lt;br&gt;UnitedHealthcare Vision Claims Department P.O. Box 30978 Salt Lake City, UT 84130 <a href="http://www.myuhcvision.com">www.myuhcvision.com</a></td>
<td>Group Number: 730193</td>
<td>Insured</td>
</tr>
<tr>
<td>Life and AD&amp;D Insurance</td>
<td>Unum</td>
<td>(800) 445-0402&lt;br&gt;Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 <a href="http://www.unum.com">www.unum.com</a></td>
<td>Basic Benefit Identification Number: 205263 011&lt;br&gt;Supplemental Benefit Identification Number: 205359 011</td>
<td>Insured</td>
</tr>
<tr>
<td>Long-Term Disability Insurance</td>
<td>Unum</td>
<td>(888) 673-9940&lt;br&gt;Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 <a href="http://www.unum.com">www.unum.com</a></td>
<td>Basic Benefit Identification Number: 205263 022&lt;br&gt;Voluntary Buy-Up Benefit Identification Number: 205263 012</td>
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<tr>
<td>Short-Term Disability Insurance</td>
<td>Unum</td>
<td>(888) 673-9940&lt;br&gt;Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122 <a href="http://www.unum.com">www.unum.com</a></td>
<td>Number: 205262 011</td>
<td>Insured</td>
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<tr>
<td>Legal</td>
<td>Legal Resources™</td>
<td>(800) 728-5768 Legal Resources 2 Bethesda Metro Center Suite 1560 Bethesda, MD 20814 <a href="http://www.legalresourcesplan.com">www.legalresourcesplan.com</a></td>
<td>N/A</td>
<td>Insured</td>
</tr>
<tr>
<td>Employee Assistance</td>
<td>ComPsych®</td>
<td>(855) 705-2471 ComPsych® Corporation NBC Tower 455 N. Cityfront Plaza Dr. Chicago, IL 60611 <a href="http://www.guidanceresources.com">www.guidanceresources.com</a></td>
<td>Code: GWU</td>
<td>Insured</td>
</tr>
<tr>
<td>COBRA</td>
<td>PayFlex</td>
<td>(800) 284-4885 PayFlex Systems USA, Inc. 10802 Faman Drive Suite 100 Omaha, NE 68154 <a href="http://www.healthhub.com">www.healthhub.com</a></td>
<td>N/A</td>
<td>not applicable</td>
</tr>
</tbody>
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APPENDIX A
Privacy and Security of Health Information

PRIVACY

The receipt, use and disclosure of protected health information ("PHI") by the Plan is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain Plan employees and the Plan’s business associates may receive, use and disclose PHI in order to carry out payment, treatment and health care operations under the Plan. These entities and individuals may use PHI for such purposes without your consent or written authorization. In general, if your PHI is used or disclosed for any other purpose, your written authorization for such use or disclosure will be required. All Plan Participants will receive a Notice of Privacy Practices that explains the Plan’s obligation to protect PHI and also describes certain rights you have with regard to your PHI.

Under this law, the Plan (or health service provider with the Plan’s permission) may disclose PHI, as defined in HIPAA, to the Plan Administrator to carry out administrative functions related to the Plan. The Plan Administrator’s administrative functions include the responsibility to control and manage the operation and administration of the Plan, in accordance with ERISA. Such administrative functions include, but are not limited to, the responsibility to determine appeals of benefit claims. The Plan Administrator may use and disclose the PHI provided to it from the Plan (or health insurance issuer or HMO) only for these purposes.

The Plan Administrator is subject to the following limitations and requirements related to the use and disclosure of PHI received from the Plan:

1. The Plan Administrator shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to HIPAA.

2. The Plan Administrator shall require any agents, including subcontractors, to whom they provide PHI received from the Plan to agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such information.

3. The Plan Administrator shall not use PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan.

4. The Plan Administrator shall promptly report to the Plan any improper use or disclosure of PHI of which they become aware.

5. The Plan Administrator shall provide adequate protection of PHI and separation between the Plan and the Plan Administrator by:
(a) ensuring that only the following university employees will have access to the PHI provided by the Plan:

- Vice President, Human Resources
- Assistant Vice President, Tax, Payroll, and Benefits Administration
- Associate Vice President for HR Administration
- Director, Benefits & Wellness
- Director, Benefits Administration
- Assistant Manager, Benefits Administration
- Benefits Associate
- Benefits Systems Analyst
- Program Administrator
- Those employees substituting for any of the positions listed above

(b) restricting access to and use of PHI to only the employees listed above for limited purposes related to their job responsibilities, and only for the administrative functions performed by the Plan Administrator on behalf of the Plan that are described above; and

(c) using the following procedures to resolve issues of noncompliance by the employees listed above: The Plan has a zero tolerance policy regarding the improper use or disclosure of PHI by any employee. Any employee who violates the Plan’s Policies and Procedures and/or the HIPAA privacy rules will be subject to sanctions at the Plan’s discretion, which may include oral counseling, write-ups, suspension, and/or termination.

6. The Plan Administrator shall:
   (a) make PHI available for access purposes in accordance with 45 C.F.R. § 164.524;
   (b) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526; and
   (c) make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

7. The Plan Administrator shall make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for audit purposes.

8. If feasible, the Plan Administrator shall return or destroy all PHI received from the Plan that the Plan Administrator retain in any form when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Administrator shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan shall disclose PHI to the Plan Administrator only upon receipt of a certification by the Plan Administrator that the Plan documents have been amended in accordance with 45 C.F.R. § 164.504(f), and that the Plan Administrator shall protect the PHI as described herein.
Please contact the Benefits Administration Department if you have any questions regarding your privacy rights.

**SECURITY**

The Plan Administrator will reasonably and appropriately safeguard the electronic PHI the Plan Administrator receives, creates or maintains by, or on behalf of, the Plan. The Plan Administrator shall:

1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Plan Administrator creates, receives, maintains or transmits on behalf of the Plan;

2. implement reasonable and appropriate security measures for the purpose of ensuring that there is adequate separation as described in paragraph (5) of the privacy section above between the Plan Administrator and the Plan;

3. ensure any agent, including a subcontractor, to whom the Plan Administrator provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

4. report to the Plan any security incident of which the Plan Administrator becomes aware; including attempted or successful unauthorized access, use, disclosure or destruction of information or interference with system operations, that involve electronic PHI provided to the Plan Administrator by, or on behalf of, the Plan.