

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

Effective as of January 1, 2016

TABLE OF CONTENTS

| | |
|--|----|
| INTRODUCTION TO YOUR BENEFITS | 3 |
| Introduction..... | 4 |
| Benefit Options | 4 |
| ELIGIBILITY, ENROLLMENT, AND PARTICIPATION | 6 |
| Key Definitions | 7 |
| Eligibility for Coverage | 8 |
| Dependents Eligible for Coverage | 9 |
| Enrolling in the Plan: Initial Eligibility | 11 |
| Open Enrollment..... | 12 |
| Changing Your Benefits During the Year | 12 |
| Special Enrollment Rights | 16 |
| When Participation Ends..... | 17 |
| If you are Rehired | 18 |
| BENEFITS AND PAYING FOR YOUR BENEFITS | 19 |
| Annual Choices | 20 |
| Available Options | 20 |
| Your Contributions | 22 |
| COBRA..... | 25 |
| Your Right to Continue Coverage – COBRA..... | 26 |
| Where You Can Learn More..... | 28 |
| SPECIAL SITUATIONS AFFECTING YOUR BENEFITS..... | 29 |
| Special Situations Affecting Your Benefits..... | 30 |
| If You Retire | 33 |
| ADMINISTRATIVE INFORMATION | 34 |
| Introduction to Administrative Information..... | 35 |
| Plan Sponsor and Administration | 35 |
| Plan Identification..... | 35 |
| Plan Year..... | 36 |
| Agent for Service of Legal Process | 36 |

| | |
|--|----|
| Not a Contract of Employment | 36 |
| Plan Continuation..... | 36 |
| Plan Funding | 36 |
| Your Rights as a Plan Participant | 37 |
| Authority of Plan Administrator | 38 |
| Decisions on Health Coverage..... | 38 |
| Qualified Medical Child Support Order (“QMCSO”)..... | 39 |
| Privacy of Health Information | 39 |
| Medical Benefit Notices | 39 |
| Third-Party Recovery/Subrogation..... | 43 |
| Benefit Payment..... | 44 |
| Anti-Assignment and Nonalienation of Benefits | 45 |
| Recoupment | 45 |
| State Law and Invalid Provisions | 45 |
| Claims Information | 46 |
| GLOSSARY | 54 |
| SERVICE PROVIDER DIRECTORY | 61 |
| APPENDIX A..... | 65 |
| Privacy and Security of Health Information | 65 |

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 a Benefit Description. 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”), each as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). 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.¹ (The university’s Plan year is the calendar year.)

This SPD does not address retirement plans, flexible spending accounts, or non-ERISA welfare benefits such as GW-Paid Short Term Disability or tuition benefits. Summaries and information for these benefits are available at <https://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

| Benefit Option | Coverage Choices |
|---|--|
| Medical (includes Virtual Visits and prescription drug coverage through CVS Caremark) | <ul style="list-style-type: none">• UnitedHealthcare Choice Plus – High Deductible Health Plan (with optional Health Savings Account)• UnitedHealthcare Choice Plus – Basic• UnitedHealthcare Choice Plus – Medium |
| Dental | <ul style="list-style-type: none">• Aetna High Option Dental PPO• Aetna Low Option Dental PPO• Aetna DMO (Dental Maintenance Organization) |
| Vision | <ul style="list-style-type: none">• UnitedHealthcare Basic Vision• UnitedHealthcare Enhanced Vision |
| Life and Accidental Death & Dismemberment (AD&D) Insurance | <ul style="list-style-type: none">• Basic Group Term Life Insurance• Basic AD&D Insurance• Additional Group Term Life Insurance• Additional AD&D Insurance |

¹ 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.

| Benefit Option | Coverage Choices |
|--|---|
| Long-Term Disability Insurance | <ul style="list-style-type: none"> • Basic Long-Term Disability Insurance • Long-Term Disability Buy-Up Insurance |
| Short-Term Disability Insurance | <ul style="list-style-type: none"> • Voluntary Short-Term Disability Insurance |
| Legal | <ul style="list-style-type: none"> • Legal Resources |
| Employee Assistance | <ul style="list-style-type: none"> • ComPsych[®] |

Important Notes on the Benefit Descriptions

This SPD, the benefit descriptions, 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 (571) 553-8382 or <https://benefits.gwu.edu>.

SECTION 2

Eligibility, Enrollment, and Participation

Key Definitions

ACA Full-Time Employee – Any common-law employee of the university who is determined by the university to be employed an average of at least 30 hours of service per week. The university may use any method of determining ACA Full-Time Employee status as may be permitted under the Affordable Care Act, and may establish any permitted measurement period and administrative period. The determination method need not be the same for all employees and may be changed at the university’s discretion and to the extent permitted by the Affordable Care Act.

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. Except to the extent an individual who is listed below is determined by the university to be an “ACA Full-Time Employee,” the term Benefits-Eligible Employee will 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 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, specialized (e.g. research and special service faculty), or visiting ranks listed in the Faculty Code and who devotes 100% effort to the duties of the position, and who receives a 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 generally appointed for one academic year and who devotes less than 100% effort to university duties (with the exception of a Partial Retiree, described above under “Full-Time Faculty Member.”). 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.²
- **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 <https://benefits.gwu.edu>.

| Eligibility Chart for Faculty Members, Staff Members and Residents | |
|--|--|
| Benefit Option | Eligibility |
| Medical Benefit (including prescription drug) | 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. |
| Dental Benefit | 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. |
| Vision Benefit | |
| Employee Assistance Benefit | ACA Full-Time Employees that are not otherwise Benefits Eligible Employees are eligible for Medical Benefits (UnitedHealthcare Choice Plus – High Deductible Health Plan option and Health Savings Account only) on the first day of the stability period that follows an applicable initial or on-going measurement period during which the individual meets the definition of “ACA Full-Time Employee” (as determined by the university) and any applicable administrative period. |
| Legal Benefit | |

² Benefits-Eligible Employees at the GW Biostatistics Center who work 35 or more hours per week are considered Full-Time Staff for purposes of benefits; those who work at least 14 but less than 35 hours per week are considered Part-Time for benefit purposes.

| Eligibility Chart for Faculty Members, Staff Members and Residents | |
|---|---|
| Benefit Option | Eligibility |
| Life and AD&D Insurance Benefit | <p>The following Benefits-Eligible Employees are eligible on the first of the month following or coincident with their date of hire:</p> <ul style="list-style-type: none"> • Full-Time and Part-Time Faculty Members • Full-Time Staff Members • Residents <p>Part-Time Staff Members are eligible on the first of the month following 6 months of continuous service.</p> |
| Long-Term Disability Insurance Benefit | <p>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.</p> <p>Part-Time Faculty Members and Part-Time Staff Members are not eligible.</p> |
| Short-Term Disability Insurance Benefit (Voluntary STD) | <p>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.</p> <p>Part-Time Faculty Members are eligible on the first of the month following or coincident with their date of hire.</p> <p>Part-Time Staff Members are eligible on the first of the month following 6 months of continuous service.</p> |

Dependents Eligible for Coverage

Benefits-Eligible Employees may enroll eligible Dependents in the Medical, Dental, Vision, Additional Life and/or AD&D Insurance (if you also select Additional Life and/or AD&D Insurance for yourself), and Legal Benefits. ACA Full-Time Employees that are not otherwise Benefits-Eligible Employees may enroll eligible Dependent children in the Medical Benefit (UnitedHealthcare Choice Plus – High Deductible Health Plan only). Dependents are automatically covered for Employee Assistance Benefits.

Eligible Dependents include:

- your Spouse (including common law marriage or same-sex marriage) or Partner;
- your or your Spouse/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/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 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
- Common-Law Spouse – “Declaration of Common-Law Marriage Partner”
- 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

The university reserves the right to audit dependent eligibility at any time. Dependents whose eligibility is not timely verified will be terminated from the Plan immediately. Participants who maintain an ineligible Dependent or Dependents on the Plan may be penalized. All decisions by the Plan Administrator regarding eligibility are final and binding, and are not subject to appeal.

If You and Your Dependents Are Both Eligible for GW Coverage

No individual may be enrolled as both a Participant and a Dependent under any Benefit Option in this Plan and/or the Health and Welfare Plan for Retired Employees, 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, your former spouse or partner is no longer eligible to participate in the Plan. If you fail to timely cancel coverage for a formerly 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 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 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 Partner may bring a civil action against you, your former Partner, or both, to recover their losses, including reasonable attorney’s fees.

Enrolling in the Plan: Initial Eligibility

You must enroll 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). You must use the university’s online enrollment tool called EasyEnroll, which can be accessed at <https://www.benedetails.gwu.edu>, to make elections for a Benefit Option of the Plan. If you do not enroll within this initial eligibility period, you will not have another opportunity to enroll until the open enrollment period, or after a qualifying life event. The university will notify you when the open enrollment period begins and ends.

When Evidence of Insurability (EOI) is Required

An additional 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.

Additional Life Insurance EOI

As a new hire, you can elect Additional 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/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/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 additional 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 additional 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 additional Spouse/Partner life coverage (and you have elected at least \$50,000 of additional 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 additional 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

Each year there will be an annual open enrollment period during which you will be allowed to make changes to your benefit elections. 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.³

Once the open enrollment period ends, you will not be able to make any substantive changes to your elections until the next open enrollment or you experience a subsequent qualifying life event. You will be able to correct any mistakes or oversights that may have been made during open enrollment in the 5 business days following open enrollment. Further, you may drop coverage for you, your spouse, and/or your dependent(s) any time between the end of open enrollment and the start of the plan year.

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.

| QUALIFYING LIFE EVENTS | | | | | | | |
|-------------------------------|---------------------|----------------------------|------------------|----------------------|-----------------------------|-------------------|--|
| Family Status Change | Add Employee | Add Spouse/ Partner | Add Child | Drop Employee | Drop Spouse/ Partner | Drop Child | Required Documentation |
| Marriage/ Partnership* | YES | YES | YES | YES*** | NO | YES** | Marriage Certificate and Birth Certificate if child also added |

³ Please note that certain other benefit programs that are not described in this SPD, such as Flexible Spending Accounts, require you to affirmatively elect to continue the benefit during each open enrollment period; otherwise the benefit will not be carried over into the new plan year. For more information, please visit <https://benefits.gwu.edu>, or call (888) 4GWUBEN (440-8326).

QUALIFYING LIFE EVENTS

| Family Status Change | Add Employee | Add Spouse/ Partner | Add Child | Drop Employee | Drop Spouse/ Partner | Drop Child | Required Documentation |
|---|---------------------|----------------------------|------------------|----------------------|-----------------------------|--------------------------------|--|
| Divorce/Legal Separation or Dissolution of Domestic Partnership or Civil Union Relationship | YES | NO | YES | NO | YES | YES (if not your Dependent) | Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership form |
| Birth or Adoption* (including a court order to add a child) | YES | YES | YES | YES*** | YES*** | YES*** | Birth Certificate, Proof of Birth or Adoption Papers |
| Guardianship | YES | NO | YES | NO | NO | NO | Legal Papers |
| Significant Change in Coverage due to Participant's Change in Employment Status* | YES | YES | YES | YES | YES | YES | None since the university has records |
| Spouse/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)* | YES*** | YES*** | YES*** | NO | NO | NO | Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer) |
| Spouse/Partner Becomes Covered by His/Her Employer | NO | NO | NO | YES*** | YES*** | YES*** | Proof of Benefit Coverage from Employer |
| Dependent Becomes Ineligible (reached maximum age) | NO | NO | NO | NO | NO | YES | No Documentation Required |
| Death of Spouse/ Partner | YES*** | NO | YES*** | NO | YES | NO | Death Certificate |
| Death of Eligible Dependent | NO | NO | NO | NO | NO | YES | Death Certificate |
| Becoming Eligible for Medicaid | NO | NO | NO | YES | YES** | YES** | Proof of Eligibility or Enrollment |

QUALIFYING LIFE EVENTS

| Family Status Change | Add Employee | Add Spouse/ Partner | Add Child | Drop Employee | Drop Spouse/ Partner | Drop Child | Required Documentation |
|--|---------------------|----------------------------|------------------|----------------------|-----------------------------|-------------------|---|
| Loss of Other Coverage* (but not due to a failure to pay COBRA premium) | YES | YES | YES | NO | NO | NO | Proof of Loss |
| Loss of Eligibility for Medicaid | YES | YES | YES | NO | NO | NO | Proof of Loss |
| Becoming Eligible for Children's Health Insurance Plan | NO | NO | NO | NO | NO | YES | Proof of Eligibility or Enrollment |
| Loss of Eligibility for Children's Health Insurance Plan | YES | YES | YES | NO | NO | NO | Proof of Loss |
| Spouse/Partner Makes Changes At Open Enrollment | YES*** | YES*** | YES*** | YES*** | YES*** | YES*** | Proof of Loss or Benefit Coverage from Employer |
| Increase in Cost Due to Change From Full-Time to Part-Time | NO | NO | NO | YES | YES | YES | No Documentation Required (if Benefits-Eligible Employee) Proof of Cost (if Spouse/ Partner) |
| Decrease in Cost Due to Change From Part-Time to Full-Time | YES | YES | YES | NO | NO | NO | No Documentation Required (if Benefits-Eligible Employee) Proof of Cost (if Spouse/ Partner) |
| Reduction in Hours Below 30**** | NO | NO | NO | YES | YES | YES | Proof of Enrollment in Another Plan that Provides Minimum Essential Coverage |

| QUALIFYING LIFE EVENTS | | | | | | | |
|--|--------------|---------------------|-----------|---------------|----------------------|------------|--|
| Family Status Change | Add Employee | Add Spouse/ Partner | Add Child | Drop Employee | Drop Spouse/ Partner | Drop Child | Required Documentation |
| Enrollment in Medical Coverage through a Health Insurance Marketplace**** | NO | NO | NO | YES | YES | YES | Proof of Enrollment in Another Plan that Provides Minimum Essential Coverage |
| <p>*If you are enrolling based on one of these events, you will have the opportunity to change coverage levels or options.</p> <p>**This change is permitted if the Benefits-Eligible Employee drops coverage.</p> <p>***This change must be consistent with the change made under a Benefits-Eligible Employee's Spouse's/Partner's plan.</p> <p>**** Medical Benefit only.</p> | | | | | | | |

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 <https://benedetails.gwu.edu>. (If you are adding or dropping a dependent due to a divorce or legal separation or due to the events described under "Special Enrollment Rights," below, you have 60 calendar days to report the event.) You will 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 certain types of leave of absence as described beginning on page 29 of this SPD), 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. If returning from leave under the Family and Medical Leave Act, your allowable changes to benefits elections will be effective on the date you return to work.

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:

| Event Date | And all required paperwork is received on: | The change will take effect on: |
|--------------|--|--|
| September 15 | September 30 | October 1 |
| September 15 | October 10 | November 1 |
| September 15 | October 17 | You have missed the 30-calendar day deadline and may not add your spouse to your coverage until the next open enrollment period to be effective January 1. |
| October 1 | September 29 | October 1 |
| October 1 | October 5 | November 1 |

Special Enrollment Rights

If you decline enrollment for yourself or your Dependents (including your Spouse/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 Benefit Options 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 Dependents

If you decline enrollment for yourself or your Dependents (including your Spouse/Partner) and later acquire a Dependent as a result of marriage, birth, adoption, or placement 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 marriage, and 60 calendar days following the birth, adoption, or placement for adoption.

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 60 calendar days of the birth, adoption, or placement for adoption, then the child's coverage will be retroactive back to the birth, adoption, or placement for adoption. If you enroll a child after 60 calendar days, then coverage will begin on the first of the month following the university's receipt of enrollment. 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, adoption, or placement for adoption.**

Other Special Enrollment Rights

If you or your Dependent (1) loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP")⁴ 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 <https://benedetails.gwu.edu>, or contact the call center at (888) 4GWUBEN (449-8326) or <https://benefits.gwu.edu>.

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 will end upon the earlier of the date:

- the Plan terminates;
- your employment with the university is terminated;⁵
- 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 or Medical Benefit option will end on the earlier of the date:

- you cease participating in the Plan;
- you cease to satisfy the definition of ACA Full-Time Employee;⁶
- you discontinue participation in a Benefit Option or Medical Benefit option during open enrollment;
- you fail to make a contribution required for a Benefit Option or Medical Benefit option;

⁴ 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.

⁵ The termination date for nine-month faculty who are not returning to the university for the fall semester is May 31.

⁶ The coverage of an employee who is otherwise not considered a Benefits-Eligible Employee under the Plan but was offered coverage under a Medical Benefit option solely on the basis of his or her "full-time employee" status under the Affordable Care Act and not the Plan's general eligibility rules, will terminate on the last day of the stability period for which the covered employee was determined to be an ACA Full-Time Employee during a preceding measurement period (as determined by the university in accordance with Treas. Reg. § 54.4980H-3).

- you go on certain types of leave of absence during which continued participation is not authorized by the terms of the Benefit Option (see “Special Situations Affecting Your Benefits,” beginning on page 29); or
- you cease to satisfy the conditions of a Benefit Option or Medical 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 enrollment or 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:

- **Medical Benefits:** If you are rehired within 365 calendar days of your termination date, your previous benefits eligible service will apply toward any applicable waiting period.
- **Life and AD&D Insurance:** If you are rehired within 365 calendar days of your termination date, your previous benefits eligible 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 benefits eligible 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 benefits eligible 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 Benefit Options 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

| For Benefits-Eligible Employees (see Eligibility section on page 8) | | |
|--|--|--|
| Benefit Option | Explanation | Cost Sharing |
| Medical (including prescription drug) | <p>You can elect to participate in one of the available Medical Benefit options or waive coverage. You can choose employee only, employee + Spouse/Partner, employee + child(ren) (this includes you plus one or more children) or employee + family (this includes you, plus a Spouse/Partner and at least one other Dependent).</p> <p>Depending on which Medical Benefit option you pick, you may also be eligible to establish and contribute to a health savings account and receive university matching contributions to your health savings account, up to annual IRS limits. Consult your Flexible Benefits Plan Summary Plan Description for additional information about health savings accounts.</p> <p>Medical Benefit Participants automatically receive the prescription drug coverage through CVS Caremark.</p> | You and the university share the cost of coverage. Your portion of the cost is paid with pretax contributions. |
| Dental | You can elect to participate in one of 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. | You pay the full cost of coverage with pretax contributions. |
| Vision | You can elect to participate in one of 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. | You pay the full cost of coverage with pretax contributions. |
| Employee Assistance | You and your Dependents are automatically covered for counseling services. There is no need to affirmatively elect this benefit during the open enrollment period or at any other time. | The university pays the full cost. |

For Benefits-Eligible Employees

(see Eligibility section on page 8)

| Benefit Option | Explanation | Cost Sharing |
|--|--|---|
| Legal | <p>You can elect to participate in the Legal Benefit in order to help protect yourself against high legal fees. You, your Spouse/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.</p> | <p>You pay the full cost of the coverage with after-tax contributions.</p> |
| <p style="text-align: center;">Life and/or AD&D Insurance</p> <p>Note: At age 70, age reductions apply to the coverage amounts described here. See the Benefit Description for details.</p> | <p><i>Basic Life and AD&D Insurance</i></p> <p>You automatically receive Basic Life and AD&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.</p> <p>In addition, a special death benefit of one month’s Benefits Salary is paid by GW to your beneficiary if you die while an active employee.⁷</p> <p>It is important to designate a beneficiary to receive your Life Insurance Benefits. Please be sure to periodically review and update your beneficiary designation as necessary.</p> | <p>The university pays the full premium for Basic Life and AD&D Insurance Benefits.</p> |
| | <p><i>Additional Life and/or AD&D Insurance</i></p> <p>You can elect optional Additional Life and/or AD&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.</p> <p>It is important to designate a beneficiary to receive your Life Insurance Benefits. Please be sure to periodically review and update your beneficiary designation as necessary.</p> | |

⁷The special death benefit is subject to forfeiture or clawback if it is determined by the university in its sole discretion that employee engaged in fraud, malfeasance, misappropriation, or other conduct detrimental to the university or its reputation.

For Benefits-Eligible Employees

(see Eligibility section on page 8)

| Benefit Option | Explanation | Cost Sharing |
|--|--|---|
| | <p><i>Dependent Life and/or AD&D Insurance</i></p> <p>If you elect optional Additional Life and/or AD&D Insurance Benefit coverage, you can elect optional Dependent Life and/or AD&D Insurance Benefit coverage for your Spouse/Partner and/or eligible Dependent children. You can elect Additional Life and/or AD&D Insurance Benefit coverage for your Spouse/Partner in increments of \$5,000 up to the lesser of 50% of your coverage or \$375,000. You can elect Additional Life and/or AD&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 additional 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.</p> | <p>You pay the full premium for any Dependent Life and/or AD&D Insurance Benefit coverage you elect with after-tax contributions.</p> |
| Long-Term Disability Insurance | <p>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 to both levels of coverage in the first 12 months after your effective date of coverage and are detailed in the Benefit Description.</p> | <p>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.</p> |
| Voluntary Short-Term Disability Insurance | <p>Part-Time Faculty and Staff Members, and Full-Time Faculty and Staff 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 coverage, your coverage in the Voluntary Short-Term Disability Insurance will end and your premiums will stop. For more information about GW-paid short-term disability insurance, please visit https://benefits.gwu.edu.</p> <p>* Benefit-eligible service means you are in a benefit eligible position.</p> | <p>You pay the full cost of your Voluntary Short-Term Disability Insurance with after-tax contributions.</p> |

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 Additional 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 Spouses, including common law spouses, and biological children or children acquired 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.

AND

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.

AND

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

If your 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 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 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.

| If Non-Qualified Tax Dependents are Covered for Medical Benefits | | |
|--|---|---|
| Who is Covered | Premium Paid by Employee (Pretax Contribution) | Imputed Income |
| <ul style="list-style-type: none"> • Employee • Partner | Employee contribution for Employee Plus Spouse/Partner coverage | Cost to the Plan of Employee Only coverage |
| <ul style="list-style-type: none"> • Employee • Partner • Employee’s Dependent child(ren) | Employee contribution for Employee Plus Family coverage | Cost to the Plan of Employee Only coverage |
| <ul style="list-style-type: none"> • Employee • Partner • Partner’s child(ren) | Employee contribution for Employee plus Family coverage | Cost to the Plan of Employee Plus Child(ren) coverage for medical and cost of family coverage for other benefits. |
| <ul style="list-style-type: none"> • Employee • Partner • Employee’s Dependent child(ren) • Partner’s child(ren) | Employee contribution for Employee plus Family coverage | Cost to the Plan of Employee Plus Child(ren) coverage for medical and cost of family coverage for other benefits. |

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 current 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.

Although the law does not require the university to offer continuation coverage to a Partner or their children (a “non-qualified tax dependent,” as explained on page 23) upon the loss of coverage, the university offers 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.

| COBRA Qualifying Event | COBRA Maximum Coverage Duration (Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below.) |
|--|---|
| Termination of employment (for any reason other than gross misconduct) | 18 months (Benefits-Eligible Employee and covered Dependents); may be extended to 29 months if a qualified beneficiary is disabled ⁷ |
| Reduction in the Benefits-Eligible Employee's hours worked, or the Benefits-Eligible Employee goes on an approved leave of absence during which Health Coverage ends | 18 months (Benefits-Eligible Employee and covered Dependents); may be extended to 29 months if a qualified beneficiary is disabled ⁸ |
| Death of the Benefits-Eligible Employee | 36 months (surviving covered Dependents) |
| Divorce, legal separation, dissolution of a common law marriage, or dissolution of a Partnership | 36 months (Spouse/former Spouse/common law spouse/Partner and covered Dependent children) |

⁸ 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.

| COBRA Qualifying Event | COBRA Maximum Coverage Duration (Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below.) |
|--|--|
| Dependent child ceases to qualify as a Dependent | 36 months |

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. However, you will be allowed a 30-day grace period to pay before your coverage is terminated for non-payment. 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.

Note that there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at <https://www.healthcare.gov>.

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 (571) 553-8382 or <https://benefits.gwu.edu> for additional information on COBRA. For more information about the Marketplace, visit <https://www.healthcare.gov>.

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.

Unpaid Personal Leave of Absence

If you are on approved unpaid personal leave of absence 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. Your Basic and Additional Life and/or AD&D Insurance Benefit coverage as well as your Voluntary Short-Term and Long-Term Disability Insurance Benefit coverage can only be continued for up to 12 months of leave. 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.

If your unpaid leave of absence is 30 calendar days or less, your portion of the cost for benefits will accrue in 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.

You may cancel your benefits within 30 calendar days of the start of your unpaid leave of absence through EasyEnroll at <https://www.benedetails.gwu.edu>. 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. 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. If you return to work within 30 days of the start of your leave, your prior elections will be reinstated.

Unpaid Leave of Absence – FMLA, ADA and Qualified Military Leaves

If you are on approved, unpaid FMLA Leave or leave as an accommodation under the Americans with Disabilities Act (ADA), you may elect to continue your Medical, Dental, Vision, Employee Assistance,

Legal, Basic Life and AD&D Insurance, Additional 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 you are on approved Qualified Military Leave, you may elect to continue your Medical, Dental, Vision, Employee Assistance and Legal benefit coverage through the duration of your leave of absence. Basic Life and AD&D Insurance, Additional Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage can only be continued up to 12 months of military leave.

If your unpaid FMLA Leave, leave under the ADA or Qualified Military Leave is 30 calendar days or less, your portion of the cost for benefits will accrue in 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 may be required to reimburse the university for the university's portion of benefit costs paid on your behalf during your FMLA Leave.**

Note: If you are on FMLA Leave, leave under the ADA or Qualified Military 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 and Military Leave Policies.) If you remain in paid status during FMLA leave or Qualified Military Leave, your benefits premiums will be deducted from your pay as normal. If the cost of your benefits exceeds your pay during your leave, the remaining unpaid premium will accrue in arrears and be deducted from your paycheck.

You may cancel your benefits within 30 calendar days of the start of your unpaid leave of absence through EasyEnroll at <https://www.benedetails.gwu.edu/>. 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. 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.

Disability Leave of Absence

If you qualify for GW paid short-term disability benefits, your Medical, Dental, Vision, Basic Life and AD&D Insurance, Additional Life and/or AD&D Insurance, Basic Long-Term Disability Insurance, Long-Term Disability Buy-Up Insurance, Employee Assistance Benefit and Legal benefit coverage will continue through the duration of your leave of absence. Deductions from your pay for benefits premiums will continue as normal. If you qualify for voluntary short-term disability benefits, your Medical, Dental, Vision, Basic Life and AD&D Insurance, Additional Life and/or AD&D Insurance, Basic Long-Term Disability Insurance, Long-Term Disability Buy-Up Insurance, Employee Assistance Benefit and Legal benefit coverage will continue through the duration of your leave of absence provided your premiums are paid. If your voluntary short term disability leave 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 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 Additional 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 Additional 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 Additional Life Insurance Benefit premiums after satisfying the applicable conditions.

You may also continue your coverage under the 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.

Other Leaves of Absence

If you are on a paid administrative leave or suspension, your Medical, Dental, Vision, Legal, and/or Employee Assistance benefit coverage will continue through the duration of your leave of absence. Deductions from your pay will continue as normal. Basic Life and AD&D Insurance, Additional Life and/or AD&D Insurance can only be continued up to 12 months of leave. Short-Term Disability Insurance and Long-Term Disability Insurance Benefit coverage can only be continued up to 90 days of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for Disability Insurance.

If you are on an involuntary, unpaid, administrative leave or suspension, your Medical, Dental, Vision, Legal, and/or Employee Assistance benefit coverage will continue through the duration of your leave of absence as long as premiums are paid. Basic Life and AD&D Insurance, Additional Life and/or AD&D Insurance, Short-Term Disability Insurance and Long-Term Disability Insurance Benefit will terminate on your last day of work. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for Disability Insurance.

If you are a Medical Resident on research assignment, you may elect to continue your Medical, Dental, Vision, Employee Assistance and Legal benefit coverage through the duration of your leave of absence as long as premiums are paid. Basic Life and AD&D Insurance, Additional Life and/or AD&D

Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage can only be continued up to 24 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for Disability Insurance.

If you are on a leave of absence for the purpose of either full-time study for an advanced degree, or work in the field of education or research such as a Fulbright Award, foundation grant, government project, or other academic research related to your field of expertise, you may elect to continue your Medical, Dental, Vision, Employee Assistance and Legal benefit coverage through the duration of your leave of absence as long as premiums are paid. If your leave of absence is paid, deductions from your pay will continue as normal. Basic Life and AD&D Insurance, Additional Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage can only be continued up to 12 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for Disability Insurance.

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 return to work within 30 days of the start of your leave, your prior elections will be reinstated.

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 in a Benefits-Eligible Employee position 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
(571) 553-8382

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
(571) 553-8324

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 508.

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 will 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.

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 will 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 covered expenses.

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

No Pre-existing Condition Exclusions

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

No Rescission of Coverage

The Plan will not cancel or discontinue Medical Benefit coverage with a retroactive effect with respect to a Participant or covered Dependent except in the event of fraud or intentional misrepresentation. A retroactive cancellation of coverage is not a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

No Lifetime or Annual Limits

The Medical Benefit will not impose a lifetime or annual limit on the dollar value of any Essential Health Benefits that are covered under the Plan.

Patient Protections

To the extent applicable, the Medical Benefit will comply with the patient protections regarding choice of health care professionals and emergency care services under section 2719A Public Health Services Act.

Preventive Services

Notwithstanding anything in this document to the contrary, in-network preventive health services will be covered at 100%. No cost-sharing (e.g., co-payments, deductibles, or coinsurance) will apply for these in-network services. “Preventive health services” have been defined to include the following:

- Evidence-based items or services with an A or B rating recommended by the United States Preventative Services Task Force.
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- Evidence-informed preventative care and screening provided for in the comprehensive guidelines support by the Health Resource and Services Administration (HRSA) for infants, children, and adolescents.
- Other evidence-informed preventative care and screening provided for in comprehensive guidelines supported by HRSA for women.

For more information, you may contact the university’s Benefits Administration Department at (571) 553-8382 or visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

Clinical Trials

The Medical Benefit will not deny any Participant or Eligible Dependent participation in an approved clinical trial for which such Participant or Eligible Dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Participant or Eligible Dependent participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms “qualified individual,” “life

threatening disease or condition,” approved clinical trial” and “routine patient costs” has the same meaning as found in section 2709 of the Public Health Services Act.

Cost Sharing

The Medical Benefit will comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the Affordable Care Act, indexed annually. For purposes of this provision, “cost-sharing” includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Medical Benefit. “Cost-sharing” does not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Medical Benefit.

Wellness Incentives

From time to time the Plan may offer wellness programs designed to promote the health and well-being of all employees. These wellness programs may provide financial incentives to engage in activities that encourage healthy lifestyle changes, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health “coaching” and participate in disease management programs, provide on-line education tools, etc. These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the university money. Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communication. Any wellness program and related financial incentive offered under the Plan shall comply with the requirements and limitations of HIPAA, the Affordable Care Act, and related guidance.

Mental Health Parity

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under the Medical Benefit, as required by section 712 or ERISA and the regulations thereunder. Specifically:

- *Lifetime or Annual Dollar Limits.* The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.
- *Financial Requirement or Treatment Limitations.* The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

- *Criteria for medical necessity determinations.* The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Medical Benefit will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

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 will 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 <https://www.insurekidsnow.gov> to find out how to apply.

Health Insurance Marketplace

The Health Insurance Marketplace offers “one-stop shopping” to find and compare private health insurance options. Coverage through the Health Insurance Marketplace may cost less than coverage under the Plan. In the Marketplace, if you are not offered coverage under the Plan, you could also be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you’ll also learn if you qualify for free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP). You can access the Marketplace for your state at <https://www.HealthCare.gov>. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit <https://www.HealthCare.gov>.

Third-Party Recovery/Subrogation

General Principle

When you or your Dependent receive benefits under the Plan that are related to medical expenses which 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 are required to 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 will 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 will 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 will constitute agreement to the Plan's right to subrogation or reimbursement.

You and your Dependent consent and agree that you or they will not assign your or their rights to settlement or recovery against a third person or party to any other party, including your or 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.

Benefit Payment

Payment of any claim for benefits will be made to the Participant (including a beneficiary, where applicable). However, for the convenience of the Plan and only upon request by the Participant, the Plan Administrator may in its sole and absolute discretion transmit payment to a person rendering services, treatment or supplies. Any direct payment by the Plan will not constitute or validate an assignment of benefits or rights under the Plan. Any direct payment by the Plan will not alter the effect of the Anti-Assignment section below, and will not entitle the party receiving such payments to any rights or benefits under the Plan, including the right to obtain documents from the Plan, appeal any benefit determinations, or file any suit against the Plan or its fiduciaries. If the Participant dies before all benefits have been paid to the Participant, the remaining benefits, if any, will be paid to the Participant's estate or to any person or corporation that has been approved by the Plan Administrator to be entitled to payment. Such payment will fully discharge the Plan's obligations with respect to that claim for Benefits. If a Participant is a minor, or not

competent to give a valid receipt for payment of any benefit due to him or her under the Plan and if no request for payment has been received from a duly appointed guardian or other legally appointed representative of that person, payment may be made directly to the individual or institution that has assumed the custody or the principal support of that person.

Anti-Assignment and Nonalienation of Benefits

Absent express written permission from the Plan Administrator or as otherwise expressly provided under the terms of this Plan, no Participant may assign any rights or benefits under the Plan, including the right to seek or receive benefits, appeal benefit determinations, obtain Plan documents, or file any suit against the Plan or its fiduciaries. Any attempt by a Participant to assign any rights or benefits under the Plan will be void. For the convenience of the Plan, the Plan Administrator, in its sole and absolute discretion, may at the request of the Participant transmit payment to a person rendering services, treatment, or supplies. Any such direct payment by the Plan shall not constitute or validate an assignment of benefits or rights under the Plan or otherwise alter the effect of this Anti-Assignment provision.

Except as otherwise expressly provided under the terms of any Benefit Description, or except as may otherwise be required by law, a Participant's rights, interests, and benefits under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, pledge, garnishment, execution, encumbrance, or charge of any kind, whether voluntary or involuntary, and any attempt to do so shall be void. If any person entitled to benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, pledge, encumber, or charge any benefit under the Plan, or if any attempt is made to subject any such benefit to the debts, contracts, liabilities, liens, or torts of the person entitled to any such benefit, except as specifically provided in the Plan, then such benefit shall cease and terminate in the discretion of the Plan Administrator, and the Plan Administrator may hold or apply the amount of such benefit or any part thereof to the benefit of any dependent of such person, in such manner and proportions as the Plan Administrator may deem proper.

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.

State Law and Invalid Provisions

Except as where specified in a Benefit Description, the Plan will be administered, construed and enforced according to the laws of the District of Columbia and in the courts situated in there, except as preempted by ERISA or other federal law.

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions will continue to be fully effective.

Claims Information

This section gives you information about filing claims and what to do if a claim is denied. To receive a benefit under a Benefit Option, you must file a claim. The following provides information on filing claims under the 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 benefits under the 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 benefits 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, and provide authorization to the university and/or the Benefit Option (as applicable) to release any protected health information relating to your claim.

Claims and Appeals Procedures

The applicable Benefit Description that describes a particular Benefit Option under the Plan may 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 will 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 applicable. 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. You must request the review on appeal in writing within 60 calendar days after the claim is denied. If you fail to submit an appeal request within the 60-day period, you 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 health care 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 retroactive termination of coverage (i.e., a rescission) 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 are 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 are 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, and will allow you no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of urgent care claims, in which event you will be provided no less than two (2) days to respond to the new evidence or rationale.

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 are 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 are 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.

No Conflict of Interest

To the extent Plan personnel are involved in the claims process, the Plan will not consider in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any claimant, whether or not such individual is likely to support the denial of benefits to a claimant.

Medical Claims – Voluntary External Appeals

You may file a voluntary appeal for external review of any adverse benefit determination or any final internal adverse benefit determination that is for a medical benefit claim and qualifies as set forth below.

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. 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.” External review is only available if your claim involves (1) medical judgment (excluding those claims that involve only contractual or legal interpretation without any use of medical judgment) as determined by the ERO, or (2) a rescission of coverage. An adverse benefit determination based upon your failure to meet the eligibility requirements under the plan isn't eligible for external review. External review is not available for claims under the Dental Benefit.

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

Subject to verification procedures and privacy policies that the Benefit Option may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

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 external appeal, any applicable statute of limitations, including the time limit set forth below under "Time Limit on Legal Proceedings," will run while the appeal is pending – it will not be tolled. 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 are 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 "Full and Fair Review of Claim Determinations and 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.

If upon the first standard level of appeal, the coverage denial is upheld and it's determined that you are 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

- **ACA Full-Time Employee** – Any common-law employee of the university who is determined by the university to be employed an average of at least 30 hours of service per week. The university may use any method of determining ACA Full-Time Employee status as may be permitted under the Affordable Care Act, and may establish any permitted measurement period and administrative period. The determination method need not be the same for all employees and may be changed at the university’s discretion and to the extent permitted by the Affordable Care Act.
- **Affordable Care Act (ACA)** – The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education and Reconciliation Act of 2010, and the regulations and guidance issued thereunder.
- **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.
- **Benefit Options** – The various health and welfare benefits provided or made available to Participants by the university as set forth herein and incorporated hereunder.
- **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: 571-553-8385, email: benefits@gwu.edu, website: <https://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. Except to the extent an individual who is listed below is determined by the university to be an “ACA Full-Time Employee,” the term Benefits-Eligible Employee will 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 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.
- **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, and Special Death 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.
- **CHIP** – The Children’s Health Insurance Program.
- **Civil Union** – A legally recognized union of a same-sex couple, with rights similar to those of marriage.
- **Civil Union Partner**– A partner of a Participant who has legally entered into a Civil Union pursuant to the applicable state’s law.
- **COBRA** – The Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, and any successor provisions thereto.
- **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 will include:
 - the legal Spouse (as defined by federal law) of the Participant, the common law Spouse of the Participant, the Partner of the Participant;
 - a Participant’s child (including stepchildren, children legally placed for adoption, legally adopted children, and children of a same-sex Partner) if such child is under age 26; provided, however, your Domestic Partner must also be enrolled in order to cover his/her child; 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 will 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.
- **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.
- **Essential Health Benefits** – Health-related items and services that fall into the following categories, as defined in section 1302 of the Affordable Care Act and further determined by the Secretary of Health and Human Services.
 - Ambulatory patient services;
 - Emergency services;
 - Hospitalization;
 - Maternity and newborn care;
 - Mental health and substance use disorder services, including behavioral health treatment;
 - Prescription drugs;
 - Rehabilitative and habilitative services and devices;
 - Laboratory services;
 - Preventive and wellness services and chronic disease management; and
 - Pediatric services, including oral and vision care.

For purposes of determining whether a benefit or services is an Essential Health Benefits for purposes of permissible annual or lifetime limits and cost-sharing limits under the Affordable Care Act, the Plan has chosen the State of Utah as its benchmark state.

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

- **Faculty Code** – The written rules approved by The Board of Trustees of The George Washington University that apply to university faculty, as it may be amended from time to time.
- **Faculty Member** –
 - **Full-Time Faculty Member** – A Benefits-Eligible Employee who is appointed for at least one academic year in one of the regular, specialized (e.g. research and special service faculty), or visiting ranks listed in the Faculty Code who devotes 100% effort to the duties of the position, and who receives a 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 generally appointed for one academic year and who devotes less than 100% effort to university duties (with the exception of a Partial Retiree, described above under “Full-Time Faculty Member.”) 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, and/or similar applicable state or local family and medical leave laws.
- **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 Benefit Plan for Retired Employees maintained by the university, as it may be amended from time to time.
- **Health Insurance Marketplace or Marketplace** – An organization set up by a state or federal government to facilitate the purchase of health insurance in accordance with the Patient Protection and Affordable Care Act of 2010.
- **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. The university may make available a telemedicine service through enrollment in one or more of the available Medical Benefit options. The telemedicine service may provide a lower cost office visit for virtual consultations under such Medical Benefit option. Where available, enrollment in the telemedicine service is automatic and made available to eligible Participants and Dependents enrolled in the applicable Medical Benefit option.
- **Participant** – A Benefits-Eligible Employee who becomes a Participant pursuant to Section 2.
- **Partner** – A Domestic Partner or Civil Union Partner.
- **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, together with any underlying Benefit Descriptions.
- **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.

- **Full-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 40 hours per week.⁹
- **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.
- **Virtual Visits** – A telemedicine service that enables you to see and speak with an in-network physician using real-time audio and video technology to obtain a diagnosis and treatment for common, minor medical needs. Where available, enrollment in the telemedicine service is automatic and made available to eligible Participants and Dependents enrolled in the applicable Medical Benefit option.
- **Vision Benefit** – The vision insurance benefit provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

⁹ Benefits-Eligible Employees at the GW Biostatistics Center who work 35 or more hours per week are considered Full-Time Staff for purposes of benefits; those who work at least 14 but less than 35 hours per week are considered Part-Time for benefit purposes.

SECTION 8

Service Provider Directory

**THE GEORGE WASHINGTON UNIVERSITY
HEALTH AND WELFARE BENEFIT PLAN**

SERVICE PROVIDER CONTACT INFORMATION

| Benefit | Provider/Claims Administrator | Contact Information | Group / Identification Number (If Applicable) | Funding * |
|---|--------------------------------------|--|--|------------------|
| Medical – Choice Plus High Deductible Health Plan – Choice Plus Basic – Choice Plus - Medium | UnitedHealthcare | (877) 706-1739 UnitedHealthcare – Claims P.O. Box 740800 Atlanta, GA 30374-0800 www.myuhc.com | Group Number: 730193 | Self-Funded |
| Prescription Drug | CVS Caremark | (877) 357-4032 CVS Caremark Customer Care Correspondence P.O. Box 832407 Richardson, TX 75083 www.caremark.com | Group Number: J226001 | Self-Funded |
| Dental – High Option PPO – Low Option PPO – Dental Maintenance Organization (DMO) | Aetna | (877) 238-6200 Aetna Dental P.O. Box 14094 Lexington, KY 40512-4094 www.aetna.com | Group Policy Number: GP-622758 | Insured |

* 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.

| Benefit | Provider/Claims Administrator | Contact Information | Group / Identification Number (If Applicable) | Funding * |
|---|-------------------------------|--|---|-------------|
| Vision – Basic – Enhanced | UnitedHealthcare | Customer Service: 800-638-3120 Provider Locator: 800-839-3242 UnitedHealthcare Vision Claims Department P.O. Box 30978 Salt Lake City, UT 84130 www.myuhcvision.com | Group Number: 730193 | Insured |
| Life and AD&D Insurance – Basic – Additional | The Standard | 855-554-2918 Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093 www.standard.com | Plan Number 649377 | Insured |
| Special Death Benefit | GW | 571-553-8382 The Benefits Administration Department The George Washington University 45155 Research Place, Suite 160 Ashburn, VA 20147 | Not Applicable | Self-Funded |
| Long-Term Disability Insurance – Basic – Buy-Up | The Standard | 855-554-2918 Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093 www.standard.com | Plan Number 649377 | Insured |
| Short-Term Disability Insurance | The Standard | 855-554-2918 Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093 www.standard.com | Plan Number 648377 | Insured |

| Benefit | Provider/Claims Administrator | Contact Information | Group / Identification Number (If Applicable) | Funding * |
|--|-------------------------------|---|---|----------------|
| Legal | Legal Resources™ | 800-728-5768 Legal Resources 2 Bethesda Metro Center Suite 1560 Bethesda, MD 20814 www.legalresources.com | Not Applicable | Insured |
| Employee Assistance | ComPsych® | 855-705-2471 ComPsych® Corporation NBC Tower 455 N. Cityfront Plaza Dr. Chicago, IL 60611 www.guidanceresources.com | Code: GWU | Insured |
| COBRA; Health Savings Account Program; Health Care and Dependent Care Flexible Spending Accounts (FSA) | PayFlex | 800-284-4885 PayFlex Systems USA, Inc. 10802 Faman Drive Suite 100 Omaha, NE 68154 www.payflex.com | Not Applicable | Not Applicable |

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 Sponsor, 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.

Disclosure To The Plan Sponsor. The Plan may disclose your PHI to the Plan Sponsor that is necessary for the Plan Sponsor to carry out the following administrative functions related to the Plan.

The Plan Sponsor needs access to PHI to:

- Determine the amount of benefits, if any, you and/or your dependent are entitled to from the Plan;
- Determine or find facts that are relevant to any claim for benefits from the Plan;
- Determine whether a participant’s benefits should be terminated or suspended;
- Perform duties relating to the establishment, maintenance and administration of the Plan;
- Communicate with participants regarding the status of their claims;
- Recover any overpayment or mistaken payments made to claimants; and
- Handle participant issues with regard to subrogation and third party claims.

The Plan Sponsor may use and disclose your PHI (provided to it from the Plan) only for the administrative purposes described above.

Limitations And Requirements Related To The Use and Disclosure of PHI. The Plan Sponsor agrees to the following limitations and requirements related to the use and disclosure of PHI received from the Plan:

1. The Plan Sponsor will 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.

- (a) When using or disclosing your PHI or when requesting your PHI from the Plan, the Plan Sponsor will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
2. The Plan Sponsor will 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 Sponsor with respect to such information.
3. Except as permitted by HIPAA and other applicable law, the Plan Sponsor will not use PHI for employment-related actions or make employment-related decisions about you, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.
5. The Plan Sponsor will 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
- Health & Wellness 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 Sponsor on behalf of the Plan that are described above;

- (c) requiring any agents of the Plan who receive your PHI to abide by the Plan's privacy rules; and

- (d) 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. The Plan will be

immediately notified of the noncompliance, and the Plan and Plan Sponsor will work together to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI. After investigation into the alleged incident, any employee who was found to have violated 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. The Plan and Plan Sponsor will work together to create new safeguards and procedures so as to prevent a future incident of noncompliance.

6. The Plan Sponsor will:
 - (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 Sponsor will 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 Sponsor will return or destroy all PHI received from the Plan that the Plan Sponsor retains 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 will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

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 will:

- (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.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan documents have been amended in accordance with 45 C.F.R. § 164.504(f), and that the Plan Sponsor will protect the PHI as described herein.

Please contact the Benefits Administration Department if you have any questions regarding your privacy rights.