The George Washington University
Health and Welfare Benefit Plan
for Retired Employees

Plan and Summary Plan Description

Effective as of January 1, 2014
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APPENDIX A
SECTION 1

Introduction to Your Benefits
Introduction

The George Washington University (the “university”) sponsors The George Washington University Health and Welfare Benefit Plan for Retired Employees (the “Plan”) to provide health and welfare benefits to eligible retirees, disabled employees and their dependents. 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 the 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 for Retired Employees (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 medical, dental and vision 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 savings plans or tuition benefits. Summaries and information for these benefits are available at http://benefits.gwu.edu, or by calling (571) 553-8382.

For your reference, this SPD includes a glossary to help you navigate through some vocabulary (see Section 6). Capitalized terms used in this SPD are defined in the glossary.

Benefit Options

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Coverage Choices</th>
</tr>
</thead>
</table>
| Medical (includes prescription drug coverage through CVS Caremark) | Non-Medicare Eligible Participants  
• UnitedHealthcare Choice Plus-Basic  
• United Healthcare Choice Premium (In-Network only)  
• United Healthcare Choice Plus-Medium  
Medicare Eligible Participants  
• UnitedHealthcare BLUE 65-PPO |
| Dental |   
• Aetna High Option Dental PPO  
• Aetna Low Option Dental PPO  
• Aetna DMO (Dental Maintenance Organization) |

¹ For those who have qualified life events during the year, other time periods will apply. Please see Section 2 for information on participation.
<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Coverage Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>• UnitedHealthcare Basic Vision</td>
</tr>
<tr>
<td></td>
<td>• UnitedHealthcare Enhanced Vision</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>• Group Term Life Insurance</td>
</tr>
</tbody>
</table>

**Important Notes on the Benefit Descriptions**

This SPD and the booklets, certificates, and other descriptive material provided or made available to you by the university and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other materials (such as an insurance policy or other contractual agreement with a healthcare or other service provider) that contain more detailed information about Plan benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan’s benefits. However, if there is any conflict or inconsistency among these materials, it is the Plan Administrator’s responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. The university reserves the right to change, amend, or terminate the Plan and any of the Benefit Options at any time and for any reason. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the university and does not give you the right to be retained in the employment of the university. No one speaking on behalf of the Plan or the university can alter the terms of the Plan. You and your beneficiaries may obtain copies of this Plan document and SPD and the Benefit Descriptions, or examine these documents by contacting the Plan Administrator at the number and address set forth in Section 5 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 http://benefits.gwu.edu.
SECTION 2

Eligibility, Enrollment, and Participation
**Key Definitions**

**Benefits-Eligible Retiree** – A former university employee who was a Benefits-Eligible Employee enrolled in the Health and Welfare Benefit Plan as of the date of retirement, and who meets one of the following requirements on the date of their retirement from the university:

- Age 65;
- Age 60 with a minimum of ten (10) years of continuous full-time or equivalent benefits-eligible service;\(^2\)
- Age 55 with a minimum of twenty (20) years of continuous full-time or equivalent benefits-eligible service;\(^2\) or
- Such other criteria as may be established by the university from time to time.

For purposes of calculating continuous years of service, a break in service of less than one year will be disregarded.

**Benefits-Eligible LTD Participant** - A university employee who is (or was) enrolled in the Health and Welfare Benefit Plan, who is on an approved disability-related leave (other than a leave covered by the Family and Medical Leave Act or the Americans with Disabilities Act, workers’ compensation or university paid leave), and who is receiving benefits under the Health and Welfare Benefit Plan’s group Long Term Disability Insurance Benefit. If you terminated employment with the university prior to being approved for long-term disability benefits, you are not eligible to participate in this Plan.

Note: Additional definitions used in this SPD can be found in the Glossary in Section 6.

**Eligibility for Coverage**

Only Benefits-Eligible Retirees and Benefits-Eligible LTD Participants, plus their eligible Dependents, may receive Medical Benefits, Dental Benefits, and Vision Benefits. For Medical Benefit purposes, Participants must live or work within the United States in order to be eligible. Only a Benefits-Eligible Retiree may receive Life Insurance Benefits in this Plan.\(^3\) 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 [http://benefits.gwu.edu](http://benefits.gwu.edu).

\(^2\) Part-time service may be aggregated and applied toward meeting the service requirement. For example, four years of part-time work on a 50% schedule would equal two years of full-time service.

\(^3\) Individuals receiving LTD benefits may be eligible for life insurance under the Health and Welfare Benefit Plan. Contact the university’s Benefits Administration Department at (571) 553-8382 for more information.
Important Information about Medicare

You should enroll in Medicare when you first become eligible in order to maximize your benefit and avoid late enrollment penalties. The Plan’s Medical Benefit and Medicare coordinate coverage when you or your dependent is eligible for both. One plan will be primary—that is, will adjudicate your claim first—and one plan will be secondary. Whether the Plan or Medicare pays first depends on your employment status and the reason you are Medicare-eligible. Further, Medicare may charge a late enrollment penalty if you do not enroll when first eligible. To obtain more information on Medicare (including late enrollment penalties) visit http://medicare.gov.

Benefits-Eligible Retirees

Benefits-Eligible Retirees become eligible for Medicare at age 65 and may submit an application for Medicare coverage as early as three months before the month in which they will reach age 65. For retirees, Medicare coverage is primary and the Plan is secondary. Even if you or your dependent does not enroll in Medicare, benefits under the Plan will be provided as if you or your dependents were enrolled in Medicare. This means the Plan will pay no more than the difference between the allowable charge under the Plan and the amount that Medicare pays, or would pay if you were enrolled.

Benefits-Eligible LTD Participants

Benefits-Eligible LTD Participants are automatically enrolled in Medicare after receiving Social Security Disability Insurance (“SSDI”) for 24 months, though Medicare coverage can be declined. While you are performing your work duties or in a job-protected leave status, for at least the first six months of receiving LTD benefits, the Plan will be primary and Medicare will be secondary. Once your employment with the university terminates, you are no longer performing your work duties due to disability, you cease to be covered by a job protected leave, or your first six months of benefits have expired, Medicare will begin to pay first and the Plan will pay second. If you have declined Medicare coverage and subsequently terminate your employment with the university, it is important that you enroll in Medicare right away in order to maximize your benefits and avoid Medicare’s late enrollment penalties.

<table>
<thead>
<tr>
<th>Eligibility Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Option</td>
</tr>
</tbody>
</table>

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## Eligibility Chart

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefit (including prescription drug)</td>
<td>Benefits-Eligible Retirees are eligible for the medical, dental and/or vision benefit option under the Health and Welfare Plan if they were enrolled in the option on their date of retirement. Coverage will be effective on the first of the month following the date of retirement. Important note: if you are a Benefits-Eligible Retiree and waive coverage under the Medical Benefit at the time you are first eligible under the Plan, that decision is irrevocable and you will not be eligible to participate in the Medical Benefit at any time in the future, but you may add dental and/or vision coverage during any open enrollment.</td>
</tr>
<tr>
<td>Dental Benefit</td>
<td>Benefits-Eligible LTD Participants are eligible if they were enrolled in a medical, dental and/or vision benefit option under the Health and Welfare Plan on their long-term disability benefits approval date. Coverage will be effective on the first of the month following the date of eligibility. If you are a Benefits-Eligible LTD Participant and waive coverage under the Medical Benefit, Dental Benefit, and/or Vision Benefit, you may later elect the coverage during any open enrollment. See the Benefits Descriptions for further information about eligibility requirements that are particular to a Benefit Option.</td>
</tr>
<tr>
<td>Vision Benefit</td>
<td>Benefits-Eligible Retirees are eligible for Life Insurance Benefits on the first calendar day following the date of retirement. Benefits-Eligible LTD Participants are not eligible for Life Insurance Benefits in this Plan; however, they may be eligible for life insurance under the Health and Welfare Benefit Plan. Contact the university’s Benefits Administration Department at (571) 553-8382 for more information.</td>
</tr>
<tr>
<td>Life Insurance Benefit</td>
<td></td>
</tr>
</tbody>
</table>

### Dependents Eligible for Coverage

If a Benefits-Eligible Retiree or LTD Participant enrolls in the Plan, he or she may also enroll eligible Dependents in the Medical, Dental and Vision Benefits. Only Dependents who are covered under the Health and Welfare Benefit Plan on the date of initial eligibility are eligible for immediate coverage under the Plan, but additional Dependents may be added at open enrollment or within 30 days of a qualifying life event.

Eligible Dependents include:
- your Spouse 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 may be asked to submit documentation verifying that they are eligible under the Benefit Option rules. You will receive a request from the Benefits Administration Department with full details on what documentation is required, when it must be provided, and where to send it. If you receive such a request, 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 or “Declaration of Common-Law Marriage Partner”
- **Domestic Partner** – “Declaration of Domestic Partnership”
- **Civil Union Partner** – civil union certificate or license
- **Child** – birth certificate or other proof of birth, adoption or guardianship

**If You and Your Dependents Are Both Eligible for University 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 Benefit Plan, and no individual may be covered as a Dependent by more than one Participant.

**If the Benefits-Eligible Retiree Dies**

When a participating retiree dies, participation in the Plan will be continued for all covered Dependents. A Spouse, Domestic Partner, or Civil Union Partner may continue until his or her death. A child may continue as long as he or she meets the requirements of a Dependent (after which they would be eligible for COBRA as explained in Section 4). The surviving spouse may make changes to their coverage, the same as any other Benefits-Eligible Retiree. The cost for continued participation in the Plan will be the same as the cost that the Benefits-Eligible Retiree would have paid and may change from time to time.

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

You are required to notify the university 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.

**If you Return to Work as a University Employee**

If you return to work at the university in a benefits eligible position, you and your Dependents will no longer be eligible for coverage under this Plan. You may be entitled to the coverage offered under the Health and Welfare Benefit Plan, instead. Contact the university’s Benefits Administration Department at (571) 553-8382 or [http://benefits.gwu.edu](http://benefits.gwu.edu) as soon as possible after your rehire, if not before.

The university offers Benefits-Eligible Retirees a contribution toward the cost of the Medical Benefit during the first 8 years of retirement. If you are rehired, your university contribution will restart upon your subsequent retirement, and will continue until you have received 8 years of contributions in total, including the period relating to your first retirement. Please note that you may continue coverage indefinitely beyond the first 8 years of retirement, but after the university contribution ends you will be responsible for the full cost of the Medical Benefit. See Section 3 for more information about paying for your benefits.

**Enrolling in the Plan: Initial Eligibility**

Once you are retired or approved for LTD benefits, PayFlex will mail you a welcome letter and invoice. Please be sure to review this information and return your completed information and payment to the Benefits Administration Department within 30 calendar days of the date you first become eligible for the Plan. You will have the option of paying your portion of the premium by check or by direct ACH debit.

If you are a Benefits-Eligible Retiree and do not enroll in the Medical Benefit upon retirement, you will not have another opportunity to enroll. If you are a Benefits-Eligible Retiree and do not enroll in the Dental and/or Vision Benefit within 30 calendar days of your retirement date, or if you are a Benefits-Eligible LTD Participant and do not enroll in any Benefit Options within 30 calendar days of your LTD benefits approval date, you will not have another opportunity to enroll until the open enrollment period or after a qualifying life event as explained below.

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**Open Enrollment**

The university will notify you when the open enrollment period begins and ends. More information will be provided then. In general, if you were previously enrolled under a Benefit Option of the Plan and you do not make a change during open enrollment, then your previous benefit elections under the Plan will carry over to the next year (unless you are no longer eligible or your coverage choice is no longer available).

**Changing Your Benefits During the Year**

Benefits-Eligible Retirees and LTD Participants may drop coverage or reduce their coverage level (for example, change from individual + one to individual only coverage) at any time. However, changes to increase any coverage may only be made during open enrollment periods or within 30 calendar days of a qualifying life event and must be consistent with the life event. Generally, changes must be on account of, and correspond with, the life events described in the following tables. The first table lists events applicable to the Medical Benefit and the second table lists events applicable to the Dental and Vision Benefit.

If you and/or your Dependent become Medicare eligible during the Plan year, the Medical Benefit option covering you and your Dependents will automatically change to UnitedHealthcare BLUE 65-PPO effective on the earlier of (1) the date Medicare becomes effective, or (2) the first day of the month following the month in which the you and/or your dependent reaches age 65. Call the Benefits Administration Department at (571) 553-8382 for additional information.

<table>
<thead>
<tr>
<th>QUALIFYING LIFE EVENTS FOR MEDICAL BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note that coverage can be dropped at any time by contacting the Plan Administrator.***</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Status Change</th>
<th>Add Retiree</th>
<th>Add LTD Participant</th>
<th>Add Spouse/Partner</th>
<th>Add Child</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage/Partnership**</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Marriage Certificate and Birth Certificate if child also added</td>
</tr>
<tr>
<td>Divorce/Legal Separation</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership form</td>
</tr>
<tr>
<td>or Dissolution of Domestic Partnership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Civil Union Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth or Adoption* (including a court order to add a child)</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Birth Certificate, Proof of Birth or Adoption Papers</td>
</tr>
<tr>
<td>Guardianship</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Legal Papers</td>
</tr>
</tbody>
</table>
## Qualifying Life Events for Medical Benefit

*Note that coverage can be dropped at any time by contacting the Plan Administrator.*

<table>
<thead>
<tr>
<th>Family Status Change</th>
<th>Add Retiree</th>
<th>Add LTD Participant</th>
<th>Add Spouse/Partner</th>
<th>Add Child</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Partner’s Employment Termination* or Spouse/Partner’s Significant Change in Coverage Due to Change in Employment Status Affecting Eligibility (such as changing from Full-Time to Part-Time)*</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)</td>
</tr>
<tr>
<td>Spouse/Partner Becomes Covered by His/Her Employer</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Benefit Coverage from Employer</td>
</tr>
<tr>
<td>Dependent Becomes Ineligible (reached maximum age)</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>No Documentation Required</td>
</tr>
<tr>
<td>Death of Spouse/Partner</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Death Certificate</td>
</tr>
<tr>
<td>Death of Eligible Dependent</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Death Certificate</td>
</tr>
<tr>
<td>Becoming Eligible for Medicaid</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Eligibility or Enrollment</td>
</tr>
<tr>
<td>Loss of Other Coverage* (but not due to a failure to pay COBRA premium)</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Loss of Eligibility for Medicaid</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Becoming Eligible for Children’s Health Insurance Plan</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Eligibility or Enrollment</td>
</tr>
<tr>
<td>Loss of Eligibility for Children’s Health Insurance Plan</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Spouse/Partner Makes Changes At Open Enrollment**</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss or Benefit Coverage from Employer</td>
</tr>
<tr>
<td>Enrollment in Medical Coverage through a Health Insurance Marketplace</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Enrollment in Another Plan that Provides Minimum Essential Coverage</td>
</tr>
</tbody>
</table>

**Family Status Changes that are not covered by COBRA:**

- Retirement
- Disability
- Death
- Loss of Eligibility for Medicaid
- Loss of Eligibility for Children’s Health Insurance Plan
- Spouse/Partner’s Employment Termination
- Significant Change in Coverage Due to Change in Employment Status Affecting Eligibility (such as changing from Full-Time to Part-Time)
- Dependent Becomes Ineligible (reached maximum age)
- Death of Spouse/Partner
- Death of Eligible Dependent
- Spouse/Partner Makes Changes At Open Enrollment
- Enrollment in Medical Coverage through a Health Insurance Marketplace

***No Documentation Required***

- Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)
- Proof of Benefit Coverage from Employer
- No Documentation Required
- Death Certificate
- Death Certificate
- Proof of Eligibility or Enrollment
- Proof of Loss
- Proof of Loss
- Proof of Loss
- Proof of Loss or Benefit Coverage from Employer
- Proof of Enrollment in Another Plan that Provides Minimum Essential Coverage
### QUALIFYING LIFE EVENTS FOR MEDICAL BENEFIT

*Note that coverage can be dropped at any time by contacting the Plan Administrator.***

<table>
<thead>
<tr>
<th>Family Status Change</th>
<th>Add Retiree</th>
<th>Add LTD Participant</th>
<th>Add Spouse/Partner</th>
<th>Add Child</th>
<th>Required Documentation</th>
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</thead>
<tbody>
<tr>
<td>Add Spouse/Partner</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Marriage Certificate and Birth Certificate if child also added</td>
</tr>
<tr>
<td>Add Child</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership form</td>
</tr>
<tr>
<td>Add Child</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Birth Certificate, Proof of Birth or Adoption Papers</td>
</tr>
<tr>
<td>Add Child</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Legal Papers</td>
</tr>
<tr>
<td>Spouse/Partner’s Employment Termination* or Spouse/Partner’s Significant Change in Coverage Due to Change in Employment Status Affecting Eligibility (such as changing from Full-Time to Part-Time)*</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)</td>
</tr>
<tr>
<td>Spouse/Partner Becomes Covered by His/Her Employer</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Benefit Coverage from Employer</td>
</tr>
</tbody>
</table>

*If you are enrolling a Dependent based on one of these events, you will have the opportunity to change among available coverage levels.

**This change must be consistent with the change made under a Benefits-Eligible Retiree’s or LTD Participant’s Spouse’s/Partner’s plan.

***For Benefits-Eligible Retirees, dropping the Medical Benefit is an irrevocable decision. You will not be able to re-enroll at a later time.

### QUALIFYING LIFE EVENTS FOR DENTAL AND VISION BENEFIT

*Note that coverage can be dropped at any time by contacting the Plan Administrator.*

<table>
<thead>
<tr>
<th>Family Status Change</th>
<th>Add Retiree</th>
<th>Add LTD Participant</th>
<th>Add Spouse/Partner</th>
<th>Add Child</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage/ Partnership**</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Marriage Certificate and Birth Certificate if child also added</td>
</tr>
<tr>
<td>Divorce/Legal Separation or Dissolution of Domestic Partnership or Civil Union Relationship</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership form</td>
</tr>
<tr>
<td>Birth or Adoption* (including a court order to add a child)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Birth Certificate, Proof of Birth or Adoption Papers</td>
</tr>
<tr>
<td>Guardianship</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Legal Papers</td>
</tr>
<tr>
<td>Spouse/Partner’s Employment Termination* or Spouse/Partner’s Significant Change in Coverage Due to Change in Employment Status Affecting Eligibility (such as changing from Full-Time to Part-Time)*</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)</td>
</tr>
<tr>
<td>Spouse/Partner Becomes Covered by His/Her Employer</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Benefit Coverage from Employer</td>
</tr>
</tbody>
</table>
# QUALIFYING LIFE EVENTS FOR DENTAL AND VISION BENEFIT

Note that coverage can be dropped at any time by contacting the Plan Administrator.

<table>
<thead>
<tr>
<th>Family Status Change</th>
<th>Add Retiree</th>
<th>Add LTD Participant</th>
<th>Add Spouse/Partner</th>
<th>Add Child</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Becomes Ineligible (reached maximum age)</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>No Documentation Required</td>
</tr>
<tr>
<td>Death of Spouse/Partner</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>Death Certificate</td>
</tr>
<tr>
<td>Death of Eligible Dependent</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Death Certificate</td>
</tr>
<tr>
<td>Becoming Eligible for Medicaid</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Eligibility or Enrollment</td>
</tr>
<tr>
<td>Loss of Other Coverage* (but not due to a failure to pay COBRA premium)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Loss of Eligibility for Medicaid</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Becoming Eligible for Children’s Health Insurance Plan</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>Proof of Eligibility or Enrollment</td>
</tr>
<tr>
<td>Loss of Eligibility for Children’s Health Insurance Plan</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss</td>
</tr>
<tr>
<td>Spouse/Partner Makes Changes At Open Enrollment**</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>Proof of Loss or Benefit Coverage from Employer</td>
</tr>
</tbody>
</table>

*If you are enrolling a Dependent based on one of these events, you will have the opportunity to change among available coverage levels.

**This change must be consistent with the change made under a Benefits-Eligible Retiree’s or LTD Participant’s Spouse’s/Partner’s plan.

## Other Requirements

To be eligible to change your benefits following a qualifying life event, you generally must report the event within 30 calendar days of the event by notifying the Plan Administrator. (If you are adding a Dependent due to a divorce or legal separation or due to loss of eligibility for Medicaid or the Children’s Health Insurance Plan, 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 and that once a Benefits-Eligible Retiree ceases to be covered by the Medical Benefit, he or she cannot re-enroll at a later date. The decision to drop retiree medical coverage is irrevocable.

**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.

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.

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

<table>
<thead>
<tr>
<th>Event Date</th>
<th>And all required paperwork is received on:</th>
<th>The change will take effect on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 15</td>
<td>September 30</td>
<td>October 1</td>
</tr>
<tr>
<td>September 15</td>
<td>October 10</td>
<td>November 1</td>
</tr>
<tr>
<td>September 15</td>
<td>October 17</td>
<td></td>
</tr>
<tr>
<td>October 1</td>
<td>September 29</td>
<td>October 1</td>
</tr>
<tr>
<td>October 1</td>
<td>October 5</td>
<td>November 1</td>
</tr>
</tbody>
</table>

**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 become ineligible under the terms of each Benefit Option. See the Benefit Descriptions for specific information about when your coverage ends.

Your participation in a particular Benefit Option will end upon the earlier of the date:

- the university terminates the Benefit Option;
- you cease to satisfy the Benefit Option’s eligibility criteria; or
- you select a different Benefit Option during open enrollment, or after a qualifying life event.

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

- you are re-employed by the university as a Benefits-Eligible Employee under the Health and Welfare Benefit Plan\(^4\);
- the Plan terminates;
- you cease participating in the Plan;
- you fail to make a required contribution;
- you cease to satisfy the definition of Benefits-Eligible Retiree or Benefits-Eligible LTD Participant; or
- you are a Benefits-Eligible LTD Participant and your LTD benefits stop for any reason and you are not eligible to become a Benefits-Eligible Retiree.

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 (except in the case of your death) or when he or she no longer satisfies the definition of an eligible Dependent (whichever happens first).

---

\(^4\) If you are enrolled in Medicare, you need to contact Medicare to inform them of your return to active employment.
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 as described in “Changing Your Benefits During the Year” beginning on page 11.

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

Available Options

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Explanation</th>
<th>Cost Sharing</th>
</tr>
</thead>
</table>
| Medical (including prescription drug) | Two types of coverage options are offered and participation is based on your Medicare eligibility. (See page 7 for information on enrolling for Medicare and maximizing your benefits.)  
  • Participants who are not Medicare-eligible and do not have any covered Dependents that are Medicare-eligible must be enrolled in the UnitedHealthcare Choice Plus Basic, Premium, or Medium options.  
  • Participants who are Medicare-eligible or who have a covered Dependent that is Medicare-eligible must be enrolled in the UnitedHealthcare BLUE 65-PPO Medical Benefit option.  
  Participants may also waive Medical Benefits, but Benefits-Eligible Retirees will not be able to re-enroll at a later time.  
Benefits-Eligible Retirees can choose from these levels of coverage: retiree only; retiree + one; and retiree + family.  
Benefits-Eligible LTD Participants can choose from these levels of coverage: individual only; individual + one; and individual + family.  
Plan Participants automatically receive the prescription drug coverage through CVS Caremark. | Benefits-Eligible Retirees  
During the first 8 years of your retirement, you and the university share the cost of coverage. The university’s contribution will terminate on December 31st of the calendar year in which you complete your 8th year of retirement and you will then begin to pay the full cost of coverage.  
Please note, if you retire and are rehired, your university contribution will restart upon your subsequent retirement, and will continue until you have received 8 years of contributions in total, including the period relating to your first retirement. The 8 year period does not reset with each retirement date.  
Benefits-Eligible LTD Participants  
You pay the full cost of coverage. |
| Dental                          | You can elect to participate in one of the available Dental Benefit options or waive coverage. You can choose individual only, individual + one, or individual + two or more 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. |
## For Benefits-Eligible Retirees and LTD Participants
(see Eligibility section on page 7)

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Explanation</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision</strong></td>
<td>You can elect to participate in one of the available Vision Benefit options or waive coverage. You can choose individual only, individual + one, or individual + two or more coverage. The Vision Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option.</td>
<td>You pay the full cost of coverage.</td>
</tr>
</tbody>
</table>
| **Life Insurance** | Benefits-Eligible Retirees automatically receive Life Insurance Benefit coverage (for the retiree only) that is based on the amount of the Basic Life Insurance Benefit in effect under the Plan on his or her last full day of active work before your retirement (“amount”). That amount of coverage is reduced each year until your 4th anniversary of retirement; however if you reach age 70 before your 4th anniversary of retirement, the amount is reduced to $2,500:  
  - On your retirement date, the amount is reduced to 80% of the amount, rounded up to the nearest $1,000.  
  - On July 1 coinciding with or next following the first anniversary of your retirement, the amount is reduced to 60% of the amount, with no rounding.  
  - On July 1 coinciding with or next following the second anniversary of your retirement, the amount is reduced to 40% of the amount, with no rounding.  
  - On July 1 coinciding with or next following the third anniversary of your retirement, the amount is reduced to 20% of the amount, with no rounding.  
  - On July 1 coinciding with or next following the fourth anniversary of your retirement, the amount is reduced to $2,500.  

The IRS considers the cost of any life coverage exceeding $50,000 “imputed income” and the university will report such amount on an IRS Form W-2, if applicable to you.  

**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.**  

(Note: Benefits-Eligible LTD Participants are not eligible for Life Insurance Benefits under the Plan; however Benefits-Eligible LTD Participants whose university employment has not terminated may be eligible for life insurance under the Health and Welfare Benefit Plan. Contact the university’s Benefits Administration Department at (571) 553-8382 for more information.) | The university pays the full premium cost. |
**Your Contributions**

Your contributions for the Plan are made monthly with after-tax dollars. Your premium payment is due on the first of each month, for coverage provided during that month. PayFlex will send invoices to your mailing address currently on file with the university. You should submit payment per the instructions on your invoice. Or, you can sign up for direct debit and eliminate the hassle of writing checks or missing a payment. If your address changes, you should contact the university immediately. If your premium is more than 30 calendar days late, your coverage will lapse and will be canceled as of the end of the last month for which you are paid in full. If you contact the university promptly, request reinstatement, and make full payment before the next premium is due, you may be entitled to reinstatement. **If you are a Benefits-Eligible Retiree and your coverage lapses a second time for failure to timely pay your premiums, you cannot re-enroll at any time in the future.**

Currently, amounts contributed by the university are not taxable income to you. However, there are exceptions for Non-Qualified Tax Dependents, which are Dependents who do not meet the federal income tax definition of a dependent. This is explained in more detail below.

**Definition of “Dependent” for Tax Purposes**

The Internal Revenue Code treats the university’s 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 university 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 the value of the coverage provided by the university on behalf of your Non-Qualified Tax Dependents under the Plan will be considered taxable income to you. This additional “imputed” amount will be reported on an IRS Form W-2. The value of the coverage provided to your Non-Qualified Tax Dependents will be based on the cost of the coverage under the Plan, as determined by the university. The chart below provides examples of this.

<table>
<thead>
<tr>
<th>If Non-Qualified Tax Dependents are Covered for Medical Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who is Covered</strong></td>
</tr>
<tr>
<td>• Retiree</td>
</tr>
<tr>
<td>• Partner</td>
</tr>
<tr>
<td>• Retiree</td>
</tr>
<tr>
<td>• Partner</td>
</tr>
</tbody>
</table>
SECTION 4

COBRA
Your Right to Continue Coverage – COBRA

The Consolidated Omnibus Budget Reconciliation Act (“COBRA”) provides you, your Spouse, and your children the right to continue current medical, dental, and vision, 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, your Spouse 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 21) upon the loss of coverage, the university offers the continuation of their Health Coverage on the same basis as COBRA.

Under COBRA, the Dependent(s) must elect COBRA coverage within 60 calendar days from the Qualifying Event, or, if later, 60 calendar days after the Dependent is provided with a notice of the right to elect COBRA coverage. A Dependent who doesn't choose COBRA coverage within this time period loses the right to elect it. 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  
|-----------------------|----------------------------------
| 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) |
| Dependent child ceases to qualify as a Dependent | 36 months |
| Death of the Benefits-Eligible LTD Participant | 36 months (covered Dependents) |

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 7: Service Provider Directory. Your Dependents may elect to continue coverage under the Health Coverage in which they were enrolled at the time the COBRA Qualifying Event occurred and must make an election within 60 calendar days of the COBRA event or receipt of the COBRA notice, whichever is later.

Each month, 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, the
individual will be allowed a 30-day grace period to pay before coverage is terminated for non-payment. In most cases coverage begins on the first day after the day the coverage would otherwise have been terminated to prevent a lapse in coverage.

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; or
- The university ceases to provide Health Coverage to Benefits-Eligible Retirees and/or LTD Participants.

**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 [http://benefits.gwu.edu](http://benefits.gwu.edu) for additional information on COBRA.

Note: The university is required by law to send a COBRA notice when coverage ends in the Health and Welfare Benefit Plan. However, it may be more economical to elect coverage under this Plan rather than COBRA coverage. If you have questions about what to do when you receive the COBRA notice, please contact the call center or Benefit Administration Department.
SECTION 5

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 for Retired Employees. The Plan Administrator for The George Washington University Health and Welfare Benefit Plan for Retired Employees 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 for Retired Employees, and Plan identification number, which is 509.
**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

**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 7 for more information.

**Your Rights as a Plan Participant**

As a Participant in The George Washington University Health and Welfare Benefit Plan for Retired Employees, 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
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**

**Pre-existing Conditions**

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

**Hospital Stays for Maternity**

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

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

**Women’s Health and Cancer Rights Act Notice**

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

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

These services 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 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](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](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.

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.

Benefit Payments to Third Parties

The Plan Administrator may elect to pay benefits directly to a healthcare provider unless the payment has already been made by the covered person. Where the healthcare provider rendering services does not have an agreement with the Plan to the contrary, the Plan Administrator may, at its election, pay benefits directly to the covered person. In the event the covered individual is deceased, benefits may be paid at the Plan Administrator’s option to the covered person’s estate, Spouse, Partner, Benefits-Eligible Retiree or Benefits-Eligible LTD Participant through whom the individual is covered, or the covered person’s closest relative as determined by the Plan Administrator.

No Assignment of Benefits

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

Claims Information

This section gives you information about filing claims and what to do if a claim is denied. To receive a benefit 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 7. 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 7 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 no appeals procedures are provided in a Benefit Description, then the procedures below will apply.

Decision On A Claim

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

Urgent Care Claims

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

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

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

**Other Claims (Pre-Service and Post-Service)**

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

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

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

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

**Ongoing Course of Treatment**

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

**Notice of Claim Denial**

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

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

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

**Standard Appeals**
You have the right to file an appeal from an adverse benefit determination relating to service(s) you have received or could have received from your 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 (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, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to the service provider at the address provided in Section 7, 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.
days (for pre-service claims) or 30 calendar days (for post-service claims) after the appeal is received.

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

**Medical Claims – Voluntary External Appeals**

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

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 6

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

- **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: [http://benefits.gwu.edu](http://benefits.gwu.edu).

- **Benefits-Eligible LTD Participant** - A university employee who is (or was) enrolled in the Health and Welfare Benefit Plan, who is on an approved disability-related leave (other than a leave covered by the Family and Medical Leave Act or the Americans with Disabilities Act, workers’ compensation or GW paid leave), and who is receiving benefits under the Health and Welfare Benefit Plan’s group Long Term Disability Insurance Benefit. If you terminated employment with the university prior to being approved for long-term disability benefits, you are not eligible to participate in this Plan.

- **Benefits-Eligible Retiree** – A former university employee who was a Benefits-Eligible Employee enrolled in the Health and Welfare Benefit Plan as of the date of retirement, and who meets one of the following requirements on the date of their retirement from the university:
  - Age 65;
  - Age 60 with a minimum of ten (10) years of continuous full-time or equivalent service;\(^5\)
  - Age 55 with a minimum of twenty (20) years of continuous full-time or equivalent service;\(^5\) or
  - Such other criteria as may be established by the university from time to time.

- **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.

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\(^5\) Part-time service may be aggregated and applied toward meeting the service requirement. For example, four years of part-time work on a 50% schedule would equal two years of full-time service.

• **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:
  
  o the legal Spouse (as defined by federal law) of the Participant, the common law Spouse of the Participant, the Partner of the Participant;

  o 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

  o 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.


• **Health Coverage** – Medical Benefits that are protected by COBRA.

• **Health and Welfare Benefit Plan** – The George Washington University Health and Welfare Benefit Plan 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.

• **Life Insurance Benefit** – The life insurance coverage provided or made available to eligible Participants, as it may exist from time to time.

• **Long-Term Disability Insurance Benefit** – The long-term disability insurance coverage provided or made available under the Health and Welfare Benefit Plan, as it may exist from time to time.

• **Medical Benefit** – The medical and prescription drug benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.

• **Participant** – A Benefits-Eligible Retiree or a Benefits-Eligible LTD Participant 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 for Retired Employees provided for herein, as it may be amended from time to time.

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

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

• **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.

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

• **Vision Benefit** – The vision insurance benefit provided or made available to eligible Participants and their Dependents, as it may exist from time to time.
SECTION 7

Service Provider Directory
## THE GEORGE WASHINGTON UNIVERSITY
### HEALTH AND WELFARE BENEFIT PLAN FOR RETIRED EMPLOYEES

### SERVICE PROVIDER CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Provider/Claims Administrator</th>
<th>Contact Information</th>
<th>Group / Identification Number (If Applicable)</th>
<th>Funding *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>UnitedHealthcare</td>
<td>(877) 706-1739</td>
<td>Group Number: 730193</td>
<td>Self-Funded</td>
</tr>
<tr>
<td>– Choice Plus Medium</td>
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<td>UnitedHealthcare – Claims</td>
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<td>– Choice Plus Basic</td>
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<td>P.O. Box 740800</td>
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</tr>
<tr>
<td>– Choice Premium (in-network only)</td>
<td></td>
<td>Atlanta, GA 30374-0800</td>
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<td>– Choice BLUE 65-PPO</td>
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<td><a href="http://www.myuhc.com">www.myuhc.com</a></td>
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<tr>
<td>Prescription Drug</td>
<td>CVS Caremark</td>
<td>(877) 357-4032</td>
<td>Group Number: J226001</td>
<td>Self-Funded</td>
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<td></td>
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<td>CVS Caremark Customer Care</td>
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<td></td>
<td>P.O. Box 832407</td>
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<tr>
<td></td>
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<td>Richardson, TX 75083</td>
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<td></td>
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<td><a href="http://www.caremark.com">www.caremark.com</a></td>
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</tr>
</tbody>
</table>

* **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.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Provider/Claims Administrator</th>
<th>Contact Information</th>
<th>Group / Identification Number (If Applicable)</th>
<th>Funding *</th>
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<tr>
<td>Dental</td>
<td>Aetna</td>
<td>(877) 238-6200</td>
<td>Group Policy Number: GP-622758</td>
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<tr>
<td>– High Option PPO</td>
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<td>Aetna Dental P.O. Box 14094 Lexington, KY 40512-4094</td>
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<td>– Low Option PPO</td>
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<td></td>
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<tr>
<td>– Dental Maintenance Organization (DMO)</td>
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<tr>
<td>Vision</td>
<td>UnitedHealthcare</td>
<td>Customer Service: (800) 638-3120</td>
<td>Group Number: 730193</td>
<td>Insured</td>
</tr>
<tr>
<td>– Basic</td>
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<td>Provider Locator: (800) 839-3242</td>
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<tr>
<td>– Enhanced</td>
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<td>UnitedHealthcare Vision Claims Department P.O. Box 30978 Salt Lake City, UT 84130</td>
<td><a href="http://www.myuhcvision.com">www.myuhcvision.com</a></td>
<td></td>
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<tr>
<td>Initial Enrollment and Ongoing Premium Payments</td>
<td>PayFlex</td>
<td>(800) 359-3921 PayFlex Systems USA, Inc. P.O. Box 2239 Omaha, NE 68103-2239</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
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<tr>
<td>COBRA</td>
<td>PayFlex</td>
<td>(800) 359-3921 PayFlex Systems USA, Inc. P.O. Box 2239 Omaha, NE 68103-2239</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
APPENDIX A
Privacy and Security of Health Information

PRIVACY

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

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

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

1. The Plan Administrator 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.

2. The Plan Administrator 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 Administrator with respect to such information.

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

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

5. The Plan Administrator 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
- Program Administrator
- Those employees substituting for any of the positions listed above

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

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

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

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

**SECURITY**

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