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

Plan and Summary Plan Description

Effective as of January 1, 2021

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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, long-term disability benefit recipients, 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 Benefit Descriptions, can help.

This document, together with the underlying Benefit Descriptions where available, 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 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 https://hr.gwu.edu/benefits, 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 in this SPD are defined in the glossary.

[1] For those who have qualified life events during the year, other time periods will apply. Please see Section 2 for information on participation.

Benefit Options

Benefit Option	Coverage Choices
Medical [2]	**Benefits-Eligible Retirees** Under Age 65 • Retiree Health Savings Plan (HSP) with optional Health Savings Account (HSA)[2] : Tier 1 – MFA Providers only (excluding MFA behavioral health providers), Tier 2 – UHC In-Network Providers (other than MFA Providers), Tier 3 – Out-of-Network Providers (including MFA behavioral health providers) Age 65 and Older[3] • Access to Private Medicare Exchange • Catastrophic Coverage Special Payments (if enrolled in Medicare Part D) • HRA for Faculty Members within eight years of their retirement date and enrolled in coverage through the Private Medicare Exchange (unless residing outside of the U.S.) **Benefits-Eligible LTD Participants** Under Age 65 • GW LTD PPO[2]: MFA Providers only (excluding MFA behavioral health providers), Tier 2 – UHC In-Network Providers (other than MFA Providers), Tier 3 – Out-of-Network Providers (including MFA behavioral health providers) Age 65 and Older[3] • Access to Private Medicare Exchange • Catastrophic Coverage Special Payments (if enrolled in Medicare Part D)
Dental	• Aetna High Option Dental PPO • Aetna Low Option Dental PPO • Aetna DMO (Dental Maintenance Organization)
Vision	• UnitedHealthcare Basic Vision • UnitedHealthcare Enhanced Vision
Life Insurance	• Group Term Life Insurance

[2] Effective June 1, 2017, Medical Benefit coverage choices are based on attaining age 65 rather than the Participant's Medicare eligibility.

[3] Coverage choices are administered by Via Benefits.

Benefit Option	Coverage Choices
Travel Assistance	• HTH Worldwide

Important Notes on the Benefit Descriptions

This SPD, the Benefit Descriptions where available, 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 GW Benefits at (571) 553-8382 or https://hr. gwu.edu/benefits.

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;[4]
- Age 55 with a minimum of twenty (20) years of continuous full-time or equivalent benefits-eligible service;[4] or
- Such other criteria as may be established by the university from time to time.[5]

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

The term "Benefits-Eligible Retiree" shall also include (i) a former university employee who was approved before June 1, 2017, for benefits under the Long Term Disability Insurance Benefit, who is enrolled in the Plan as of the date of retirement, and who will meet the age and service requirements above at the end of their Long Term Disability Insurance Benefit approval period; and (ii) a former university employee who was approved on or after June 1, 2017, for benefits under the Long Term Disability Insurance Benefit, who is enrolled in the Health and Welfare Plan on their termination date, and who met the age and service requirements above on their termination date.

With respect to the Medical Benefit Option only, a Benefits-Eligible Retiree will also include a

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[4] 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. Years on approved long term disability may apply towards the benefits-eligible retirement service requirement for those participants approved for a Long Term Disability Insurance Benefit prior to June 1, 2017. Contact GW Benefits at (571) 553-8382 for more information.

[5] If you received a severance benefit during the period starting July 1, 2020, and ending August 11, 2021, and you meet the University's eligibility requirements to retire as of your separation date, you will be deemed a retiree effective as of your separation date and be eligible for benefits in accordance with the terms of the Plan. If you chose the "Lump Sum & COBRA Election Option," your separation date is the "Elimination Date," which is fourteen days after you were notified of the elimination of your position. Under the "Salary and Benefits Continuation Option," your separation date is the last day of your salary and benefits continuation period, also known here and throughout this Plan document as the "severance period."

former MFA, Inc. (the "MFA") employee who:

- Was a Tenured Faculty Member at the university as of June 30, 2000;
- Was employed by the MFA on July 1, 2000;
- Was enrolled in a medical benefit option offered by the university on June 30, 2000;
- Was enrolled in a medical benefit option offered by MFA immediately prior to retirement;
- Was actively employed by the MFA at the time of retirement;
- Meets the age and service requirements set forth above, when service with the MFA and the university are combined; and
- Notifies GW Benefits, in writing, within thirty days of retirement from the MFA that he or she wants to participate in the Plan.

Benefits-Eligible LTD Participant –

"Benefits-Eligible LTD Participant" shall mean an employee whose employment with the university was terminated after being approved for the Long Term Disability Insurance Benefit and who was enrolled in the Health and Welfare Benefit Plan, but does not meet the age and service requirements for a Benefits-Eligible Retiree (described above) on the date of their termination. If your employment with the university was terminated prior to being approved for the Long Term Disability Insurance Benefit, you are not eligible to participate in this Plan.

Note: A Tenured Faculty Member who was approved for a Long Term Disability Insurance Benefit shall be eligible for participation in the Health and Welfare Benefit Plan, and become eligible as a Benefits-Eligible Retiree under this Plan at the time of retirement in accordance with the Plan terms then in effect. Any Participant in the middle of a course of treatment for a life-threatening disease on the date he or she would otherwise transition to coverage under this Plan or a new benefit option under this Plan will, with the approval of the Plan Administrator, remain eligible to participate in the plan or benefit option that was in effect when the treatment began, unless the benefit option has been terminated. The Participant will transition to the correct plan or benefit option as soon as possible after the course of treatment is complete.

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

General Eligibility Information

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, all options (except the HRA) require Participants to reside within the United States for at least six months of the year in order to be eligible; check the Benefit Descriptions for details. For the Health Reimbursement Arrangement (HRA), only former Faculty Members may be eligible to receive university contributions. Only a Benefits-Eligible Retiree may receive Life

Insurance Benefits in this Plan. To determine whether you are eligible to participate in a Benefit Option, please read the eligibility information contained in the following eligibility chart. For complete information regarding eligibility, you should also refer to the underlying Benefit Descriptions available at https://hr.gwu.edu/benefits.

For Travel Assistance Benefit purposes, Participants must be under age 70 and enrolled in a health benefit designed to be the first payer of claims before the Travel Assistance Benefit (such as the Plan's Medical Benefit). For a Dependent child to be eligible for the Travel Assistance Benefit, he or she must be unmarried and traveling with the Benefits-Eligible Retiree or Benefits-Eligible LTD Participant. The Travel Assistance Benefit is only for travel on university business that is approved in advance by the International Programs office.

Eligibility Chart	
Benefit Option	**Eligibility**
Medical Benefit Dental Benefit Vision Benefit	Benefits-Eligible Retirees are eligible for the retiree medical, dental and/or vision benefit options if they were enrolled in an option under the Health and Welfare Benefit Plan (or under the Plan as a Benefits-Eligible LTD-Participant) on their date of retirement. If you are younger than age 65, the Medical Benefit option has three tiers: Tier 1 for medical services performed by MFA Providers (other than MFA behavioral health providers); Tier 2 for in-network medical providers (other than MFA providers); and Tier 3 for out-of-network medical providers (including MFA behavioral health providers), with copayments and coinsurance amounts that vary in each tier. Coverage will be effective on the first of the month following the date of retirement. Eligibility for Health Reimbursement Arrangement contributions is described following this chart. Benefits-Eligible LTD Participants are eligible for the LTD Participant benefit options if they were enrolled in a medical, dental and/or vision benefit option under the Health and Welfare Benefit Plan on their termination date.[6] If you are younger than age 65, the Medical Benefit option has three tiers: Tier 1 for medical services performed by MFA Providers (other than MFA behavioral health providers); Tier 2 for in-network medical providers (other than MFA providers); and Tier 3 for out-of-network medical providers (including MFA behavioral health providers), with copayments and coinsurance amounts that vary in each tier. Coverage will be effective on the first of the month following that date. Eligibility for Health Reimbursement Arrangement contributions is described following this chart. **Important note: if you 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**

[6] Benefits-Eligible LTD Participants whose Long Term Disability Insurance Benefit claims were approved prior to June 1, 2017, are eligible for medical, dental, and vision benefits under the Plan if they were employed and enrolled in an option under the Health and Welfare Plan at the time their Long Term Disability Insurance Benefit claim was approved.

Eligibility Chart	
Benefit Option	**Eligibility**
	(including receiving university contributions to an HRA), but you may add dental and/or vision coverage during any open enrollment.[7] See the Benefit Description for further information about eligibility requirements that are particular to a Benefit Option.
Travel Assistance Benefit	Benefits –Eligible Retirees are eligible for the Travel Assistance Benefit on their date of retirement. Benefits-Eligible LTD Participants are eligible for the Travel Assistance Benefit on their termination date.
Life Insurance Benefit	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 GW Benefits at (571) 553-8382 for more information.

Eligibility for Catastrophic Coverage Special Payments and Access to Private Medicare Exchange

The following Participants are eligible for (i) access to the Private Medicare Exchange, and (ii) Catastrophic Coverage Special Payments (provided the Participant is enrolled in individual medical insurance through the Private Medicare Exchange):

- Benefits-Eligible Retirees and/or their eligible Spouses or Domestic Partners who are age 65 or older; and
- Benefits-Eligible LTD Participants and/or their Dependents who are age 65 or older.

Eligibility for HRA Contributions

Former Faculty Members meeting the following requirements are eligible for university contributions to an HRA:

[7] If you elected to receive a severance benefit under the "Salary Continuation Option," acceptance of benefits under the George Washington University Health and Welfare Benefit Plan during the severance period shall not constitute a waiver of the Medical Benefit under this Plan by an individual who would otherwise have become a Benefits-Eligible Retiree based on age and service at the outset of the severance period. However, you must timely enroll for benefits under the Plan at the end of the severance period as set forth under *Enrolling in the Plan: Initial Eligibility*.

- Benefits-Eligible Retirees who: (i) were Faculty Members; (ii) are age 65 or older; and (iii) are within eight years[8] of their retirement date. Enrollment in individual medical insurance through the Private Medicare Exchange is required (unless the Benefits-Eligible Retiree resides outside of the U.S., in which case Private Medicare Exchange enrollment is not required).

- Benefits-Eligible LTD Participants: No Benefits-Eligible LTD Participants will receive HRA contributions.

Important Information about Medicare

You should consider enrolling 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 https://www.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 and their Dependents who are eligible for Medicare, the Plan provides access to a Private Medicare Exchange where you may purchase individual medical insurance to supplement Medicare coverage.

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. Except in limited circumstances, if you are a Benefits-Eligible LTD Participant under age 65 who is eligible for Medicare, or are enrolled in Medicare, Medicare will be the primary payer of your claims and the Plan will be the secondary payer. Benefits under the Plan will be provided as if you were enrolled in Medicare. If you are eligible for but declined Medicare coverage, you should contact Medicare right away in order to maximize your benefits and avoid Medicare's late enrollment penalties. If you are a Benefits-Eligible LTD Participant age 65 and over, the Plan provides access to a Private Medicare Exchange where you may purchase individual medical insurance to supplement Medicare coverage.

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. Eligible Dependents are

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[8] The university HRA contribution period is determined by subtracting the months and years of retirement that occurred prior to the month in which you turn age 65 from the maximum permissible cost-sharing period of 8 years.

automatically covered for Travel Assistance Benefits when traveling with a Benefits-Eligible Retiree or LTD Participant. 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 calendar 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 must submit documentation verifying that they are eligible under the Benefit Option rules. You will receive a request from GW Benefits 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 Plan Administrator 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" and required documents as listed in the declaration
- Civil Union Partner – civil union certificate or license
- Child – birth certificate or other proof of birth, adoption or guardianship

The university reserves the right to audit Dependent eligibility at any time. Dependents whose eligibility is not timely verified will be terminated from the Plan immediately. Participants who maintain an ineligible Dependent or Dependents on the Plan may be penalized. If you disagree with the Plan Administrator's determination, you may appeal in accordance with the procedures described under *Plan Eligibility Determinations* in Section 5 of this Plan document.

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, except coverage in the Travel Assistance Benefit ends. A Spouse, Domestic Partner, or Civil Union Partner may continue to be covered under the Plan until their death. A child may continue to be covered under the Plan as long as he or she meets the Dependent eligibility requirements (after which they would be eligible for COBRA as explained in Section 4). The surviving Spouse may make changes to their coverage under the same conditions 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 the Benefits-Eligible LTD Participant Dies

When a participating Benefits-Eligible LTD Participant dies, coverage in the Plan ends and any covered Dependents would be eligible for COBRA as explained in Section 4.

If a Covered Dependent Becomes Ineligible for Coverage

You are required to notify the Plan Administrator within 30 calendar days if your covered Dependent no longer satisfies the criteria to be a covered Dependent (60 days if you and your covered Dependent divorce or legally separate, and 60 days if your covered Dependent dies). 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 GW Benefits with written notice of such occurrence. To do so, you must complete and return a "Dissolution of Domestic Partnership" form available from GW Benefits 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 in accordance with the plan terms then in

effect. Contact GW Benefits at (571) 553-8382 or https://hr. gwu.edu/benefits as soon as possible after your rehire, if not before.

If you later retire, your benefits during retirement will be determined under this Plan in accordance with the Plan terms then in effect. If you are eligible for any university contribution toward the cost of your benefits under this Plan, your previous periods of retirement will be combined with any subsequent periods in determining your maximum eligibility for university contributions. See Section 3 for more information about paying for your benefits.

Enrolling in the Plan: Initial Eligibility

When you first become a Benefits-Eligible Retiree or a Benefits-Eligible LTD Participant, PayFlex will mail you a welcome letter and invoice.[9] To enroll, you must review this information and return your completed information and payment to PayFlex within 30 calendar days of the date you first become eligible for the Plan. You can't participate in the Plan until you enroll in accordance with procedures set forth by the Plan Administrator. You will have the option of paying your portion of the premium by check or by direct ACH debit.

If you do not enroll in the Medical Benefit when first eligible under the Plan, you will not have another opportunity to enroll. If you do not enroll in the Dental and/or Vision Benefit within 30 calendar days of your initial eligibility date, you will not have another opportunity to enroll until the open enrollment period or after a qualifying life event as explained below.

Open Enrollment

The Plan Administrator (or its designee) 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 (60 days for a divorce/legal separation or death). 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.

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[9] If you are receiving severance benefits when you would have otherwise first become a Benefits-Eligible Retiree, PayFlex will contact you at the end of your severance period.

Changing your Private Medicare Exchange Insurance

If you have questions about making enrollment changes to your individual medical insurance under the Private Medicare Exchange, you should direct them to the Private Medicare Exchange provider listed in the *Service Provider Directory*.

If You Become Eligible for Medicare During the Plan Year

Benefits-Eligible Retirees

If you turn age 65 during the Plan year, your coverage under the Plan's medical options will cease and you will gain access to the Private Medicare Exchange and Catastrophic Coverage Special Payments. If you are a Faculty Member, you may also be eligible for an HRA.

Benefits-Eligible LTD Participants

If you turn age 65 during the Plan year, your coverage under the Plan's medical options will cease on the earlier of (1) the date that Medicare becomes effective, or (2) the first day of the month following the month in which you reach age 65. You will then gain access to the Private Medicare Exchange and Catastrophic Coverage Special Payments.

You must elect changes in accordance with procedures set forth by the Plan Administrator. Call GW Benefits at (571) 553-8382 for additional information.

QUALIFYING LIFE EVENTS FOR MEDICAL BENEFIT ***Note that coverage can be dropped at any time by contacting the Plan Administrator.******					
Family Status Change	**Add Retiree**	**Add LTD Participant**	**Add Spouse/ Partner**	**Add Child**	**Required Documentation**
Marriage/ Partnership*	NO	YES	YES	YES	Marriage Certificate and Birth Certificate if child also added
Divorce/Legal Separation or Dissolution of Domestic Partnership or Civil Union Relationship	NO	YES	NO	YES	Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership form
Birth or Adoption* (including a court order to add a child)	NO	YES	YES	YES	Birth Certificate, Proof of Birth or Adoption Papers
Guardianship	NO	YES	NO	YES	Legal Papers

QUALIFYING LIFE EVENTS FOR MEDICAL BENEFIT *Note that coverage can be dropped at any time by contacting the Plan Administrator.******					
Family Status Change	**Add Retiree**	**Add LTD Participant**	**Add Spouse/ Partner**	**Add Child**	**Required Documentation**
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)*	NO	YES**	YES**	YES**	Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)
Spouse/Partner Becomes Covered by Own Employer	NO	NO	NO	NO	Proof of Benefit Coverage from Employer
Dependent Becomes Ineligible (reached maximum age)	NO	NO	NO	NO	No Documentation Required
Death of Spouse/ Partner	NO	YES**	NO	YES**	Death Certificate
Death of Eligible Dependent	NO	NO	NO	NO	Death Certificate
Becoming Eligible for Medicaid	NO	NO	NO	NO	Proof of Eligibility or Enrollment
Loss of Other Coverage* (but not due to a failure to pay COBRA premium)	NO	YES	YES	YES	Proof of Loss
Loss of Eligibility for Medicaid	NO	YES	YES	YES	Proof of Loss
Becoming Eligible for Children's Health Insurance Plan	NO	NO	NO	NO	Proof of Eligibility or Enrollment
Loss of Eligibility for Children's Health Insurance Plan	NO	YES	YES	YES	Proof of Loss
Spouse/Partner Makes Changes At Open Enrollment**	NO	YES**	YES**	YES**	Proof of Loss or Benefit Coverage from Employer
Enrollment in Medical Coverage through a Health Insurance Marketplace	NO	NO	NO	NO	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.**** **Family Status Change**	**Add Retiree**	**Add LTD Participant**	**Add Spouse/ Partner**	**Add Child**	**Required Documentation**
*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. *****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.* **Family Status Change**	**Add Retiree**	**Add LTD Participant**	**Add Spouse/ Partner**	**Add Child**	**Required Documentation**
Marriage/ Partnership**	YES	YES	YES	YES	Marriage Certificate and Birth Certificate if child also added
Divorce/Legal Separation or Dissolution of Domestic Partnership or Civil Union Relationship	YES	YES	NO	YES	Divorce Decree or Legal Separation Document or Dissolution of Domestic Partnership form
Birth or Adoption* (including a court order to add a child)	YES	YES	YES	YES	Birth Certificate, Proof of Birth or Adoption Papers
Guardianship	YES	YES	NO	YES	Legal Papers
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)*	YES	YES	YES	YES	Proof of Change in Coverage (COBRA Notice, Certificate of Coverage Notice or Notice from Employer)
Spouse/Partner Becomes Covered by Own Employer	NO	NO	NO	NO	Proof of Benefit Coverage from Employer

QUALIFYING LIFE EVENTS FOR DENTAL AND VISION BENEFIT *Note that coverage can be dropped at any time by contacting the Plan Administrator.*					
Family Status Change	**Add Retiree**	**Add LTD Participant**	**Add Spouse/ Partner**	**Add Child**	**Required Documentation**
Dependent Becomes Ineligible (reached maximum age)	NO	NO	NO	NO	No Documentation Required
Death of Spouse/ Partner	YES	YES	NO	YES	Death Certificate
Death of Eligible Dependent	NO	NO	NO	NO	Death Certificate
Becoming Eligible for Medicaid	NO	NO	NO	NO	Proof of Eligibility or Enrollment
Loss of Other Coverage* (but not due to a failure to pay COBRA premium)	YES	YES	YES	YES	Proof of Loss
Loss of Eligibility for Medicaid	YES	YES	YES	YES	Proof of Loss
Becoming Eligible for Children's Health Insurance Plan	NO	NO	NO	NO	Proof of Eligibility or Enrollment
Loss of Eligibility for Children's Health Insurance Plan	YES	YES	YES	YES	Proof of Loss
Spouse/Partner Makes Changes At Open Enrollment**	YES	YES	YES	YES	Proof of Loss or Benefit Coverage from Employer
*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 or dropping a Dependent due to a divorce/legal separation or death, or adding a Dependent 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 60 calendar days, as applicable) or it will be treated as a late enrollment and you will be

required to wait until the next open enrollment period, except as noted below for a newborn or newly-adopted child.

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 you cease to be covered by the Medical Benefit, you cannot re-enroll at a later date. The decision to drop 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. 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.** If you miss the 60-day deadline, your new child's coverage will take effect on the first day of the month following the date you submit all required documentation.

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

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

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;[10]
- 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 Long Term Disability Insurance Benefit stops for any reason. However, if you were approved for a Long Term Disability Insurance Benefit before June 1, 2017, you may be eligible to become a Benefits-Eligible Retiree under the Plan.

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 a Benefits-Eligible Retiree's death) or when he or she no longer satisfies the definition of an eligible Dependent (whichever happens first).

When coverage under the Plan ends, you or your Dependents may be provided with an opportunity to elect a continuation of Health Coverage as explained in the *COBRA* section.

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[10] 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 if you have a qualifying life event as described in "Changing Your Benefits During the Year" beginning on page 15.

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

Available Options

For Benefits-Eligible Retirees and LTD Participants **(see General Eligibility Information section beginning on page 9)**		
Benefit Option	**Explanation**	**Cost Sharing**
Medical **Note: Participants may waive Medical Benefits, but will not be able to re-enroll at a later time.**	If you are a Benefits-Eligible Retiree, your options are based on whether you are age 65. (See page 10 for information on enrolling for Medicare and maximizing your benefits.) • Benefits-Eligible Retirees and their Dependents who are under age 65 may enroll in the Retiree Health Savings Plan* with optional HSA. This Medical Benefit option has three tiers: Tier 1 for medical services performed by MFA Providers (other than MFA behavioral health providers); Tier 2 for in-network medical providers (other than MFA providers); and Tier 3 for out-of-network medical providers (including MFA behavioral health providers), with copayments and coinsurance amounts that vary in each tier. • Benefits-Eligible Retirees and their Dependents who are age 65 or older will receive access to a Private Medicare Exchange and Catastrophic Coverage Special Payments. In addition, eligible Faculty Members may receive university contributions to an HRA. For example, if you are age 66 and your Spouse is age 62, then you may take advantage of access to individual medical insurance through the Private Medicare Exchange and your Spouse may enroll in the Retiree Health Savings Plan* with optional HSA. Benefits-Eligible Retirees and their Dependents can choose from these levels of coverage: retiree only; retiree + one; retiree + family. The Benefits-Eligible Retiree must be covered for any eligible Dependents to receive coverage unless the Benefits-Eligible Retiree has died, in which case survivor(s) can select from these levels of coverage: spouse only; child only; 2 children only; and 3 or more children. Once you access insurance through the Private Medicare Exchange, you and each Medicare-eligible Dependent receive individual coverage through the Private Medicare Exchange.	Benefits-Eligible Retiree: You pay the full cost of coverage, unless you are a former Faculty Member who is eligible for a premium subsidy and/or an HRA contribution for eight years following your retirement date.

For Benefits-Eligible Retirees and LTD Participants (see General Eligibility Information section beginning on page 9)		
Benefit Option	**Explanation**	**Cost Sharing**
	If you are a Benefits-Eligible LTD Participant, your options are based on whether you are age 65. (See page 10 for information on enrolling for Medicare and maximizing your benefits.) • Benefits-Eligible LTD Participants and their Dependents who are under age 65 may enroll in the GW LTD PPO*. This Medical Benefit option has three tiers: Tier 1 for medical services performed by MFA Providers (other than MFA behavioral health providers); Tier 2 for in-network medical providers (other than MFA providers); and Tier 3 for out-of-network medical providers (including MFA behavioral health providers), with copayments and coinsurance amounts that vary in each tier. • Benefits-Eligible LTD Participants and their Dependents who are age 65 or older receive access to a Private Medicare Exchange and Catastrophic Coverage Special Payments effective. For example, if you are age 66 and your Spouse is age 62, then you have access to individual medical insurance through the Private Medicare Exchange and your Spouse may enroll in the GW LTD PPO. Benefits-Eligible LTD Participants and their eligible Dependents can choose from these levels of coverage: LTD Participant only; LTD Participant + one; LTD Participant + family. Once you access coverage through the Private Medicare Exchange, you and each Medicare-eligible Dependent receive individual coverage through the Private Medicare Exchange. The Benefits-Eligible LTD Participant must be covered for any eligible Dependents to receive coverage unless the Benefits-Eligible LTD Participant has died, in which case survivor(s) will be offered COBRA. * Participants enrolled in this Medical Benefit option automatically receive prescription drug coverage through CVS Caremark.	Benefits-Eligible LTD Participant: 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 coverage for individual only; individual + one; or individual + two or more. The Dental Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option. If you are eligible for the Private Medicare Exchange, you may elect dental coverage through the Plan (via PayFlex) or the Exchange.	You pay the full cost of coverage.

For Benefits-Eligible Retirees and LTD Participants (see General Eligibility Information section beginning on page 9)		
Benefit Option	**Explanation**	**Cost Sharing**
Vision	You can elect to participate in one of the available Vision Benefit options or waive coverage. You can choose coverage for individual only; individual + one; or individual + two or more. The Vision Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option. If you are eligible for the Private Medicare Exchange, you may elect vision coverage through the Plan (via PayFlex) or the Exchange.	You pay the full cost of coverage.
Travel Assistance	You are automatically covered for Travel Assistance Benefits when you are travelling on behalf of the university and your trip is approved by the International Programs office. The benefit is designed to reimburse unexpected, medically necessary expenses that occur during travel, such as emergency medical and dental treatment, medical evacuation, travel for a bedside visit by a loved one, and repatriation of remains. The maximum total benefit is $250,000 and the payment of benefits is subject to the terms of the insurance policy.	The university pays the full cost of coverage.
Life Insurance	Benefits-Eligible Retirees: You will automatically receive Life Insurance Benefit coverage (for the retiree only) that is based on the amount of your Basic Life Insurance Benefit in effect under the Plan on your last full day of active work before your retirement ("amount"). That amount of coverage is reduced at retirement, and each year thereafter, until your 4th anniversary of retirement; at no time on or after retirement will the amount of coverage exceed the coverage in effect on your last full day of active work before retirement: • 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. Coverage is reduced to $2,500 when you reach age 70, even if that occurs before the fourth anniversary of your retirement. 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.	The university pays the full cost of coverage.

For Benefits-Eligible Retirees and LTD Participants (see General Eligibility Information section beginning on page 9)		
Benefit Option	**Explanation**	**Cost Sharing**
	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. Benefits-Eligible LTD Participants: You are not provided a Life Insurance Benefit under this Plan, but may be eligible for life insurance benefits under the Health and Welfare Benefit Plan. Contact GW Benefits at (571) 553-8382 for more information.	

Access to Private Medicare Exchange

The Plan will provide access to a Private Medicare Exchange, where individual medical insurance to supplement Medicare coverage can be purchased. Benefits-Eligible Retirees and their Dependents (including a surviving Spouse or Domestic Partner) who are age 65 or older will have access. Benefits-Eligible LTD Participants and their Dependents who are age 65 or older will also have access. See Appendix B for more information.

Catastrophic Coverage Special Payments

All Participants (including Dependents) enrolled in individual medical insurance using the Plan's access to the Private Medicare Exchange are eligible for Catastrophic Coverage Special Payments. These payments provide reimbursement of eligible prescription drug expenses above the annual catastrophic level of a Medicare Part D plan. For 2017, the catastrophic level is reached at $4,950 in out-of-pocket prescription drug expenses. (Out-of-pocket expenses include the deductible, Participant expenses prior to the donut hole, and donut hole expenses inclusive of the 58% manufacturers' discount). With this benefit, the university is limiting your annual Medicare Part D out-of-pocket costs to the catastrophic threshold.

To request payment, you must submit a Catastrophic Coverage Special Payments Reimbursement Request Form along with documentation showing the catastrophic threshold has been met. Documentation can be the monthly Medicare Part D Explanation of Benefits (EOB) your receive that indicates you have reached the threshold. Each month in which you fill a prescription using your Medicare Part D plan you receive an EOB that includes your total drug costs and out-of-pocket costs for the calendar year. After meeting the threshold each year, you should continue to submit a Catastrophic Coverage Special Payments Reimbursement Request Form after each month during which you incur prescription drug expenses in order to request reimbursement. **All reimbursement requests must be postmarked no later than March 31 of the calendar year following the date the drug expense was incurred.**

Eligible prescription drug expenses are limited to prescription drug co-pays and coinsurance (but not prescription drug plan premiums) incurred on or after the date you reach the catastrophic threshold. Only expenses eligible under the Medicare Part D prescription drug plan are covered. Reimbursements are excluded from taxable income.

Contact information for the vendor administering Catastrophic Coverage Special Payments is provided in the *Service Provider Directory* section.

Health Reimbursement Arrangement (HRA)

University's HRA Contribution

The university will annually credit an eligible Faculty Member's HRA (Health Reimbursement Arrangement) with an amount (currently $2,400 per year[11]) for a period of up to 8 years following retirement.[12] (See *Eligibility for HRA Contributions*, page 10, to determine if you are eligible for the university's HRA contribution.) An eligible Participant MUST enroll in individual medical insurance through the Private Medicare Exchange to be eligible for the university's HRA contribution (unless he or she resides outside of the U.S., in which case Private Medicare Exchange enrollment is not required). The university reserves the right to reduce or eliminate this contribution at any time for any reason.

Participant Contributions Not Allowed

Under IRS rules, only employers may contribute to an HRA; Participants may not contribute.

Reimbursements from the HRA

Your HRA will be credited with university contributions. At any time, you may receive reimbursement for eligible medical expenses, up to the amount in your HRA. An HRA is merely a bookkeeping account and investment gains or losses are not credited.

After you pay premiums to your insurance company or pay out-of-pocket medical expenses to your provider, you submit a reimbursement request (or claim) for reimbursement from your HRA. Reimbursement can be submitted in one of four ways: mail, fax, online or automatic reimbursement if it is offered at the time of enrollment by your insurance carrier.

To receive reimbursement you must provide proof of your reimbursable expense such as an "explanation of benefits" or "EOB," or, if no EOB is provided, a written statement from the provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred.

Reimbursements cannot exceed the HRA balance at any time. For example, if your HRA balance is $1,600 and you submit an eligible reimbursement request for $2,000, then $1,600 would be processed.

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[11] The university's HRA contribution will be prorated if a Participant is eligible for less than 12 months of the year.

[12] The university shares the cost of medical coverage with Benefits-Eligible Retirees who are Faculty Members for a period not to exceed 8 years. The duration of your university HRA contribution period will be 8 years, minus the number of months of your retirement prior to the month in which you turn age 65.

For more information on the claims process, contact the vendor listed in the *Service Provider Directory*.

Eligible Medical Expenses

Expenses are eligible only to the extent that they are not paid by another source, such as Medicare or insurance. Expenses that exceed the balance in your HRA as of the date on which the claim is processed will not be reimbursed.

Eligible medical expenses are, in most cases, those that would qualify as deductions on your federal income tax return (if you were able to take a tax deduction for them). IRS Publication 502 summarizes types of expenses that are deductible. Below is a chart of examples of expenses that may be reimbursed by your HRA.

For a complete list of eligible health care expenses, request Publication 502 from the IRS by accessing www.irs.gov. Keep in mind that IRS regulations may change from year to year. You may be reimbursed for over-the-counter drugs/medicines only if prescribed[13] by a doctor (with the exception of insulin). Examples of over-the-counter medicines requiring a prescription include those for indigestion and acid control, colds and flu, and pain relief. However, over-the-counter items that are NOT considered drugs/medicines are eligible without a prescription (such as bandages, arm/leg/back braces, crutches/mobility aids and contact lens supplies.

Premiums you pay on an after-tax basis for your individual medical insurance (such as with access to the Private Medicare Exchange), dental or vision insurance, or Medicare Part B and Part D are eligible for reimbursement from your HRA.

Eligible Medical Expense Examples	
Medical Care examples: • Blood, plasma, oxygen. • Hospital, surgical or medical treatment charges exceeding insurance reimbursement maximums. • Deductible, copayment and coinsurance expenses not paid under medical plan coverage. • Doctor's office or home visits. • Experimental surgery. • Hospital room and board charges over the semiprivate room rate. • Intravenous transfusions. • Physical examinations.	Rehabilitation examples: • Physical therapy. • Prosthetic devices. • Special equipment. Hearing Care examples: • Audiometric exam. • Hearing aid batteries. • Hearing aid. • Hearing exam. Special Education Training examples: • Braille training. • Learning disability treatment.

[13] A prescribed medicine means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Eligible Medical Expense Examples	
• Prescribed drugs. • Prescribed vitamins. • Private duty nursing care. • Syringes, needles and injections. • Transportation for treatment. • Treatment for substance abuse. • Treatment for mental health by a psychiatrist, psychologist or social worker. • Vaccinations.	• Lip-reading training. • Sign language training. <u>Vision Care examples:</u> • Prescription glasses. • Contact lenses. • Eye exam by optometrist or ophthalmologist.

The HRA is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive generally are not taxable to you. However, the university cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, consult your personal tax advisor.

Unused HRA Balances

If you do not use the entire balance of your HRA during the year, the credit remains in your account for future years. You can use that HRA balance to reimburse yourself for premiums or eligible out-of-pocket expenses incurred in later years (subject to IRS rules at that time). You cannot withdraw leftover amounts for other uses.

Dependent's Access to the HRA

Eligible medical expenses for Spouses and Dependents (except Domestic Partners and their children) may be reimbursed from your HRA balance. Under IRS rules, expenses incurred by Domestic Partners (and their children) are not eligible for reimbursements from your HRA.

After Your Death

If you die without a surviving Spouse, your HRA is immediately forfeited upon death, but your estate or representatives may submit claims for eligible medical expenses incurred by you before your death for the six months following your date of death. After six months, the HRA will terminate and will not be reinstated.

If you die and are survived by a Spouse, your remaining HRA credit balance can be used for the reimbursement of your Spouse's eligible medical expenses incurred after your death.

Your Premium Payments

Your share of premium payments 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 your coverage lapses a second time for failure to timely pay your premiums, you cannot re-enroll at any time in the future.**

Participants with access to the Private Medicare Exchange are responsible for paying their individual medical insurance premiums directly to the insurance carrier they select through the Private Medicare Exchange. A Faculty Member's HRA balance may be used to pay these premiums.

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. University contributions to your HRA may only be used to reimburse medical expenses for a Qualified Tax Dependent.

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 whose 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 the individual and the individual's 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 your Partner's 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 your Partner's 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 your Partner's 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.

If Non-Qualified Tax Dependents are Covered for Medical Benefits		
Who is Covered	**Premium Paid by Participant**	**Imputed Income**
• Participant • Partner	Participant contribution for Participant + one coverage	Cost to the Plan of Participant Only coverage
• Participant • Partner • Participant's Dependent child(ren)	Participant contribution for Participant + family coverage	Cost to the Plan of Participant Only coverage
• Participant • Partner • Partner's child(ren)	Participant contribution for Participant + family coverage	Cost to the Plan of Participant + one coverage for medical and cost of Participant + family coverage for other benefits.
• Participant • Partner • Participant's Dependent child(ren) • Partner's child(ren)	Participant contribution for Participant + family coverage	Cost to the Plan of Participant + one coverage for medical and cost of Participant + family coverage for other benefits.

SECTION 4

COBRA

Dependents' Right to Continue Coverage – COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") provides 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 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 30) 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 (Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below.)**
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)

Other Information

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 Benefits-Eligible LTD Participants.

Where You Can Learn More

You can contact the call center at (888) 4GWUBEN (449-8326) or GW Benefits at (571) 553-8382 or https://hr.gwu.edu/benefits 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. There may also be other coverage options for you and your family through the Health Insurance Marketplace. If you have questions about what to do when you receive the COBRA notice, please contact the call center or GW Benefits. For more information about the Marketplace, visit https://www.HealthCare.gov.

Benefits-Eligible LTD Participant's Opportunity to Continue Coverage

If a Benefits-Eligible LTD Participant's coverage under the Plan ceases because he or she no longer receives Long Term Disability Insurance Benefits, then the Participant may continue Health Coverage for up to 18 months on the same basis as COBRA. Coverage may be extended an additional 11 months if the Participant is determined to have been disabled during the first 60 calendar days of continued coverage and written notice of such determination is provided to GW Benefits or PayFlex within 60 calendar days of the date of the determination and before the original 18-month continuation period expires. Details about making an election and paying for coverage will be provided at the time this opportunity is available.

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:

GW Benefits
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 GW Benefits first. If GW Benefits 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:

Corporation Service Company
1090 Vermont Ave., NW
Washington, DC 20005

Plan Continuation

The university (acting through the Executive Vice President and Chief Financial Officer) 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 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact GW Benefits. 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 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

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).

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

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

Health Insurance Marketplace

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

Third-Party Recovery/Subrogation

General Principle

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

Specific Requirements and Plan Rights

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

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

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

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

Participant Duties and Actions

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

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

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

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

Benefit Payment

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

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

Anti-Assignment and Nonalienation of Benefits

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

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

Recoupment

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

State Law and Invalid Provisions

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

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

Plan Eligibility Determinations

The Plan Administrator or the Plan Administrator's delegate makes determinations regarding eligibility for benefits under the Plan, such as whether an employee or former employee has properly and timely enrolled in coverage self-only or Dependent coverage, whether a participant is entitled to change his enrollment mid-year, and whether a requested mid-year change is consistent with the event that triggered the change, among others. In the event of an adverse determination, including a denial, reduction, or termination of coverage based on a determination regarding an individual's eligibility to participate in the Plan, the determination may be appealed by contacting GW Benefits.

Claims for Benefits

To receive a benefit under a Benefit Option, you must file a claim. This section provides information on filing Participant claims for benefits and what to do if a claim is denied. For addresses and phone numbers please refer to Section 7. In most cases, addresses are also listed on the claim form.

A "claim" is a request for benefits that is filed by a Plan Participant or beneficiary or an authorized representative in accordance with the applicable claims procedures. A request to determine eligibility under the Plan is not a "claim" under the rules set forth here under the heading *Claims for Benefits*, nor is a request for prior approval of a benefit or service where prior approval is not required under the Benefit Option. 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.

Filing a Claim

Claims for benefits under the Benefit Options should be made to the claims administrator or 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.

In general, claims must be filed in writing with the appropriate claims administrator or service provider. If a claim is received, but there is not enough information to allow the claims administrator or service provider to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the claims administrator identifying such authorized representative, and provide authorization to the university and/or the Benefit Option (as applicable) to release any protected health information relating to your claim.

Claims and Appeals Procedures

The applicable Benefit Description that describes a particular Benefit Option under the Plan may contain a specific set of claims and appeals procedures that you must follow to make a claim to

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

Decision On A Claim

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

Urgent Care Claims

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

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

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

Other Claims (Pre-Service and Post-Service)

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

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

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

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

Ongoing Course of Treatment

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

Notice of Claim Denial

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

Appeal Procedure

If a claim is denied, you may write to the claims administrator for a review of the claim on appeal. 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 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:

- 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 (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 Plan eligibility determination appeal or 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-Eligible LTD Participant** –

  A Benefits-Eligible LTD Participant shall mean an employee whose employment with the university was terminated after being approved for the Long Term Disability Insurance Benefit and who was enrolled in the Health and Welfare Benefit Plan, but does not meet the age and service requirements for a Benefits-Eligible Retiree (described above) on the date of their termination. If your employment with the university was terminated prior to being approved for the Long Term Disability Insurance Benefit, 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 benefits-eligible service;[14]

  - Age 55 with a minimum of twenty (20) years of continuous full-time or equivalent benefits-eligible service;[14] or

  - Such other criteria as may be established by the university from time to time.[15]

  For purposes of calculating continuous years of service, a break in service of less than one

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[14] 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. A severance period during which you receive salary continuation benefits is not applied toward the service requirement; however, benefits under this Plan will not commence until the end of the salary continuation period. Years on approved long term disability may apply towards the benefits-eligible retirement service requirement for those participants approved for a Long Term Disability Insurance Benefit prior to June 1, 2017. Contact GW Benefits at (571) 553-8382 for more information.

[15] If you received a severance benefit during the period starting July 1, 2020, and ending August 11, 2021, and you meet the University's eligibility requirements to retire as of your separation date, you will be deemed a retiree effective as of your separation date and be eligible for benefits in accordance with the terms of the Plan. If you chose the "Lump Sum & COBRA Election Option," your separation date is the "Elimination Date," which is fourteen days after you were notified of the elimination of your position. Under the "Salary and Benefits Continuation Option," your separation date is the last day of your severance period.

year will be disregarded.

A Benefits-Eligible Retiree shall also include (i) a former university employee who was approved before June 1, 2017, for benefits under the Long Term Disability Insurance Benefit, who is enrolled in the Plan on the date of retirement, and who will meet the age and service requirements above at the end of their Long Term Disability Insurance Benefit approval period; and (ii) a former university employee who was approved on or after June 1, 2017, for benefits under the Long Term Disability Insurance Benefit, who was enrolled in the Health and Welfare Plan on their termination date, and who met the age and service requirements above on their termination date.

With respect to the Medical Benefit Option only, a Benefits-Eligible Retiree will also include a former MFA, Inc. (the "MFA") employee who:

- Was a Tenured Faculty Member at the university as of June 30, 2000;
- Was employed by the MFA on July 1, 2000;
- Was enrolled in a medical benefit option offered by the university on June 30, 2000;
- Was enrolled in a medical benefit option offered by MFA immediately prior to retirement;
- Is actively employed by the MFA at the time of retirement;
- Meets the age and service requirements set forth above, when service with the MFA and the university are combined; and
- Notifies GW Benefits, in writing, within thirty days of retirement from the MFA that he or she wants to participate in the Plan.

- **Catastrophic Coverage Special Payments –** Reimbursements provided to Medicare eligible Benefits-Eligible Retirees and to Benefits-Eligible LTD Participants who are age 65 or older, after reaching the Medicare Part D catastrophic out-of-pocket expenses level.
- **CHIP** – The Children's Health Insurance Program.
- **Civil Union –** A legally recognized union of a same-sex couple, with rights similar to those of marriage.
- **Civil Union Partner**– A partner of a Participant who has legally entered into a Civil Union pursuant to the applicable state's law.
- **COBRA** – The Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, and any successor provisions thereto.
- **Dental Benefit –** The dental insurance benefit provided or made available to eligible

Participants and their Dependents, as it may exist from time to time.

- **Dependent** – Unless otherwise specified in the Plan or the applicable Benefit Description, the term Dependent will include:

  - the legal Spouse (as defined by federal law) of the Participant, the common law Spouse of the Participant, the Partner of the Participant;

  - a Participant's child (including stepchildren, children legally placed for adoption, legally adopted children, and children of a same-sex Partner) if such child is under age 26; provided, however, your Domestic Partner must also be enrolled in order to cover your Partner's child; and

  - a Participant's child who is age 26 or older if such child is a "qualifying child" as defined in Section 152 of the Code and regulations promulgated thereunder.

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

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

- **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.

- **Faculty Code** – The written rules approved by the George Washington University Board of Trustees that apply to university faculty, as it may be amended from time to time**.**

- **Faculty Member** –

  - **Full-Time Faculty Member –** A Benefits-Eligible Employee who is appointed for at least one academic year in one of the regular, specialized (e.g. research and special service faculty), or visiting ranks listed in the Faculty Code, who devotes 100% effort to the duties of the position, and who receives a salary through the university. Faculty appointed on a temporary basis (one semester or less) are not included. Full-Time Faculty Member also includes a Partial Retiree as provided in the Faculty Code, which is a Benefits-Eligible Employee who is a Full-Time Faculty Member who reduces their workload to either a

two-thirds or a half-time basis. Such Partial Retiree will continue to be eligible for benefits as a Full-Time Faculty Member during the partial retirement period.

- **Part-Time Faculty Member –** A Benefits-Eligible Employee who is generally appointed for one academic year and who devotes less than 100% effort to university duties (with the exception of a Partial Retiree, described above under "Full-Time Faculty Member."). Part-time faculty who are on one-semester appointments or who are compensated on a per-course basis are not included.

- **GW Benefits** – The office located on the Virginia Science and Technology Campus where your benefits under this Plan are serviced with the assistance of service providers. The contact information is: 45155 Research Place, Suite 160, Ashburn, VA 20147, Ph: (888) 4GWUBEN (449-8236), Fax: 571-553-8385, email: benefits@gwu.edu, website: https://hr.gwu.edu/benefits.

- **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.

- **HRA or Health Reimbursement Arrangement** – A tax-free account that allows reimbursement for qualified medical expenses meeting certain IRS requirements. An HRA may only be funded by employer contributions. Unused balances rollover from year to year, and accumulate if not used.

- **HSA or Health Savings Account** – A tax-free account that allows reimbursement for qualified medical expenses meeting certain IRS requirements. An HSA can be funded by employer contributions or Participant contributions, provided the recipient is enrolled in a qualifying medical plan. Contributions to an HSA roll over from year to year, and accumulate if not used.

- **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. The university may make available a telemedicine service through enrollment in one or more of

the available Medical Benefit options. The telemedicine service may provide a lower cost office visit for virtual consultations under such Medical Benefit options. Where available, enrollment in the telemedicine service is automatic and made available to eligible Participants and Dependents enrolled in the applicable Medical Benefit option.

- **MFA Provider –** A medical professional whose services are billed to the Plan using the federal tax identification number of the University Medical Faculty Associates, Inc. (MFA), other than a provider of behavioral health services.

- **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.

- **Private Medicare Exchange** - A resource that provides access to an assortment of individual medical insurance options that supplement Medicare coverage.

- **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.

- **Staff Member** – A Benefits-Eligible Employee of the university who is a regular full-time or regular part-time, graded or ungraded employee, who is not classified as a Faculty Member.

- **Tenured Faculty Member** – A Faculty Member who has been appointed and approved for tenure as provided in the university's Faculty Code. (A Tenured Faculty Member who was approved for a Long Term Disability Insurance Benefit shall be eligible for participation in the Health and Welfare Benefit Plan, and become eligible as a Benefits-Eligible Retiree under this Plan at the time of retirement in accordance with the Plan terms then in effect.)

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

- **University** – The George Washington University.

- **Virtual Visits –** Telemedicine appointments provided by UnitedHealthcare vendors Teladoc, Amwell, or Doctor on Demand that enable you to see and speak with an in-network physician using real-time audio and video technology to obtain a diagnosis and treatment for common, minor medical needs. Where available, enrollment in the telemedicine service is automatic and made available to eligible Participants and Dependents enrolled in the applicable Medical Benefit option. Telemedicine appointments provided by your physician are not Virtual Visits.

- **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

Benefit	**Provider/Claims Administrator**	**Contact Information**	**Group / Identification Number (If Applicable)**	**Funding ∗**
Medical – Retiree Health Savings Plan – Choice BLUE 65-PPO – GW LTD PPO	UnitedHealthcare	877-706-1739 UnitedHealthcare – Claims P.O. Box 740800 Atlanta, GA 30374-0800 www.myuhc.com	Group Number: 730193	Self-Funded
Prescription Drug	CVS Caremark	877-357-4032 CVS Caremark Customer Care Correspondence P.O. Box 832407 Richardson, TX 75083 www.caremark.com	Group Number: RX6475	Self-Funded
Access to a Private Medicare Exchange	Via Benefits (assists you in accessing a medical insurer)	1-(855) 232-5748 https://my.viabenefits.com/gw	Not Applicable	Not Applicable
Catastrophic Coverage Special Payments	Via Benefits	1-(855) 232-5748 https://my.viabenefits.com/gw	Not Applicable	Self-Funded
Health Reimbursement Arrangement (HRA)	Via Benefits	1-(855) 232-5748 https://my.viabenefits.com/gw	Not Applicable	Self-Funded

∗ Self-Funded: The university has contracted with the organization to provide administrative and claims administration services under the Plan for the benefit. Benefits are paid entirely by the university from its general assets and not by the organization.

Insured: The university has contracted with the insurance company to provide these benefits under the Plan. Benefits are paid entirely by the insurance company in accordance with the terms of the Plan and the policy. All claims decisions are made by the insurance company.

Benefit	Provider/Claims Administrator	Contact Information	Group / Identification Number (If Applicable)	Funding *
Dental – High Option PPO – Low Option PPO – Dental Maintenance Organization (DMO)	Aetna	877-238-6200 Aetna Dental P.O. Box 14094 Lexington, KY 40512-4094 www.aetna.com	Group Policy Number: GP-622758	Insured
Vision – Basic – Enhanced	UnitedHealthcare	Customer Service: 800-638-3120 Provider Locator: 800-839-3242 UnitedHealthcare Vision Claims Department P.O. Box 30978 Salt Lake City, UT 84130 www.myuhcvision.com	Group Number: 730193	Insured
Life Insurance	Lincoln Life Assurance Company of Boston	888-787-2129	Plan Number SA3-880-054582-01	Insured
Travel Assistance	4 Ever Life Insurance Company (through a policy issued to HTH International Group Insurance Trust)	For emergencies during travel: HTH Worldwide toll-free at 800-257-4823 or collect at 610-254-8771 Insurer: 4 Ever Life Insurance Company 2 Mid America Plaza Suite 200 Oakbrook Terrace, IL 60181 (800) 621-9215	4EL-6457-16	Insured

Benefit	Provider/Claims Administrator	Contact Information	Group / Identification Number (If Applicable)	Funding *
Initial Enrollment and Ongoing Premium Payments for Plan benefits	PayFlex	800-359-3921 Claims Fax: 402-231-4310 PayFlex Systems USA, Inc. P.O. Box 953374 St. Louis, MO 63195-3374 www.payflex.com	Not Applicable	Not Applicable
COBRA	PayFlex	800-359-3921 PayFlex Systems USA, Inc. P.O. Box 953374 St. Louis, MO 63195-3374 www.payflex.com	Not Applicable	Not Applicable

APPENDIX A

Privacy and Security of Health Information

PRIVACY

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

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

The Plan Sponsor needs access to PHI to:

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

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

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

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

    (a) When using or disclosing your PHI or when requesting your PHI from the Plan, the Plan Sponsor will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

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

3. Except as permitted by HIPAA and other applicable law, the Plan Sponsor will not use PHI for employment-related actions or make employment-related decisions about you, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. The Plan Sponsor will promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

5. The Plan Sponsor will provide adequate protection of PHI and separation between the Plan and the Plan Administrator by:

   (a) ensuring that only the following university employees will have access to the PHI provided by the Plan:

   - Vice President and Chief People Officer
   -
   - Associate Vice President, Total Rewards
   - Director, Benefits
   - Manager, Benefits
   - Benefits Associate/Consultant
   - 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 Sponsor on behalf of the Plan that are described above;

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

   (d) using the following procedures to resolve issues of noncompliance by the employees listed above: The Plan has a zero tolerance policy regarding the improper use or disclosure of PHI by any employee. The Plan will be immediately notified of the noncompliance, and the Plan and Plan Sponsor will work together to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI. After investigation into the alleged incident, any employee who was found to have violated the Plan's Policies and Procedures and/or the HIPAA privacy rules will be subject to sanctions at the Plan's discretion, which may include oral counseling, write-ups, suspension, and/or termination. The Plan and Plan Sponsor will work together to create new safeguards and procedures so as to prevent a future incident of noncompliance.

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

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

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

SECURITY

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

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

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

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

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

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

Please contact GW Benefits if you have any questions regarding your privacy rights.

APPENDIX B

About the Private Medicare Exchange

This section describes Via Benefits, the vendor that delivers access to the Private Medicare Exchange to certain participants and their dependents.

Via Benefits is a company experienced in helping Medicare-eligible individuals evaluate and enroll in individual medical insurance that works with Medicare. Via Benefits is not an insurance company. Via Benefits provides access to a Private Medicare Exchange containing a wide assortment of individual medical insurance options from more than 100 of the largest and most popular national and regional insurance companies.

The university has chosen Via Benefits because of Via Benefits' expertise in helping individuals who are Medicare eligible find and enroll in supplemental medical insurance in the individual market. The coverage that you purchase through Via Benefits is individual coverage, not a benefit under the Plan. Via Benefits' online tools, as well as access to benefits advisors, are services provided at no cost to you.

After you have enrolled in individual medical insurance through Via Benefits, Via Benefits will be your advocate for the lifetime of your enrollment. If your medications or health needs change, or you relocate, contact Via Benefits to determine if your insurance is still right for you. They are available to help you make changes when necessary.

Via Benefits contact information is provided in the *Service Provider Directory* section of this SPD.

APPENDIX C

SPECIAL PROVISIONS RELATING TO THE COVID-19 NATIONAL PANDEMIC EMERGENCY

The following provisions required under the Families First Coronavirus Response Act ("FFCRA"), the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), the Consolidated Appropriations Act, 2021, as well as other changes mandated by or permitted by guidance issued by the Internal Revenue Service ("IRS") or Department of Labor ("DOL") or authorized by the university in connection with the COVID-19 national pandemic emergency shall take effect as set forth below.

I. COVID-19 Testing

Effective as of March 18, 2020, all medical plan options under the Plan shall provide certain items and services as required under the FFCRA and the CARES Act. Specifically, such plans shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the coronavirus disease pandemic, regardless of whether the items or services are so furnished by an in-network or out-of-network health care provider:

A. A test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that is (i) approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, (ii) allowed pursuant to an emergency use authorization under section 564 of the Federal Food, Drug and Cosmetic Act, (iii) being developed and used in States who have notified HHS, and (iv) any other test allowed by Secretary of HHS, and the administration of any such test;

B. Items and services furnished to an individual during a health care provider visit (including an in-person visit and a telemedicine visit), urgent care center visit, or emergency room visit that results in an order for or administration of a test described in the bullet above, but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such test; and

C. The cost of items and services furnished during a health care office visit (whether in person or via telemedicine), urgent care visit or emergency room visit that results in the administration of, or order for, a COVID-19 test, but only to the extent such items or services relate to the administration of a COVID-19 test or the evaluation of whether a test is needed.

These services will not be subject to any prior authorization or other medical management requirements. To the extent these services are rendered by an in-network provider, the Plan will cover the cost at 100%, meaning the individual will not be required to pay any deductible, co-payment or co-insurance. To the extent such services are rendered by an out-of-network provider, the Plan will pay the maximum amount required by law and the

individual may be required to pay the difference. If you participate in the GW Health Savings Plan, you will still be permitted to contribute to the Health Savings Account in 2020 and 2021, even though medical care services and items related to COVID-19 testing and treatment are covered before the applicable HDHP minimum deductible is satisfied.

II. Preventive Services

Effective March 27, 2020, all medical plan options under the Plan shall provide "qualifying coronavirus preventive services" without cost sharing (including deductibles, copayments, and coinsurance) as required under the CARES Act. For this purpose, "qualifying coronavirus preventive services" shall mean an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is—

A. an evidence-based item or service that has in effect a rating of "A" or "'B" in the current recommendations of the United States Preventive Services Task Force; or

B. an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Any such qualifying coronavirus preventive service shall be provided as of the date that is 15 business days after the date on which a recommendation is made by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention relating to the qualifying coronavirus preventive service.

III. Other Services

From the period of March 18, 2020, until September 30, 2020, the Plan will cover 100% of the costs of all Virtual Visits. An individual with coverage under the HSP may receive coverage for Virtual Visits before satisfying the HSP's deductible and still contribute to an HSA. During this time, costs are covered for all appointment types (e.g., sore throats, allergies, seasonal flu) and suspected or confirmed COVID-19 cases.

The Plan will cover 100% of the cost of all Virtual Visits that are COVID-testing related until the end of the national public health emergency period.

All other telemedicine appointments, including Virtual Visits that are non-COVID related, are subject to the applicable copay or deductible/coinsurance rates.

IV. Extension of Certain Deadlines

In accordance with IRS and DOL guidance, the period of time known as the "Outbreak Period" must be disregarded when determining whether certain actions under the Plan are timely. The Outbreak Period runs from March 1, 2020, until the date that is 60 days after the announcement of the end of the COVID-19 public health emergency, or such other date announced by the IRS and DOL, not to exceed one year from the date an action would otherwise have been required or permitted. Accordingly, the Outbreak Period will be disregarded until the earlier of (a) 1 year from

the date the Participant was first eligible for relief, or (b) the end of the Outbreak Period for purposes of determining the following deadlines:

A. The time period an employee has to enroll in the Plan after they have a special enrollment event (i.e., 30 days or 60 days after the event, depending on the event);

B. The time period an employee has to notify the Plan of a qualifying event that would make the employee (or a family member) eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), such as a divorce, separation or a child ceasing to meet the Plan's eligibility requirements (i.e., 60 days after the qualifying event);

C. The time period for the Plan to send a COBRA election notice once it learns of a qualifying event that a qualified beneficiary or the University reports (such as a termination for reasons other than gross misconduct, reduction in hours, or layoff, divorce, etc.) (i.e., 30 days);

D. The time period to notify the Plan of a disability determination from the Social Security Administration in order to extend the COBRA period from 18 to 29 months (60 days after the determination)

E. The time period to elect to COBRA continuation coverage (i.e., 60 days after receiving the COBRA election notice);

F. The time period to pay premiums after COBRA continuation coverage is elected (45 days for the initial premium, by the first of the month for each month of coverage thereafter subject to a 30-day grace period);

G. The time period to file a benefit claim; and

H. The time period to appeal the denial of a benefit claim (i.e., 180 days after a denied health care claim or 60 days after any other denied claim).