

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

Effective as of January 1, 2022

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SECTION 1

Introduction to Your Benefits

Introduction

The George Washington University (the “university”) is committed to offering its benefits-eligible employees a comprehensive benefits package at a competitive cost. GW offers employee benefits in a way that gives you choice and flexibility so that you can choose the benefits that are right for you and your family. To get the most out of the university’s benefits offerings, you will need to understand how the benefits work, when you can receive benefits, and what steps you must follow. This document, along with the applicable 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 (the “Plan”) and the Plan’s summary plan description (“SPD”), each as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan offers you the choice of various levels of coverage so you can pick the level that best meets your needs. When you enroll during designated enrollment periods, we will ask you to make decisions about your benefits. That means you should evaluate your needs, learn about your options, and choose benefit levels that will protect you and any eligible family members for a full year.¹ (The Plan year is the calendar year.)

This SPD does not address retirement plans, flexible spending accounts, or non-ERISA welfare benefits such as GW-Paid Short Term Disability or tuition benefits. Summaries and information for these benefits are available at <https://hr.gwu.edu/benefits>, or by calling (888) 4GWUBEN (449-8326).

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

Benefit Options

Benefit Option	Coverage Choices
<p align="center">Medical (includes Virtual Visits, prescription drug coverage through CVS Caremark)</p>	<ul style="list-style-type: none"> • GW Health Savings Plan (HSP) (with optional Health Savings Account): 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) • GW PPO Plan: 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)
<p align="center">Dental</p>	<ul style="list-style-type: none"> • Aetna High Option Dental PPO • Aetna Low Option Dental PPO • Aetna DMO (Dental Maintenance Organization)

¹ For those who have qualified life events or terminate employment from the university during the year, other time periods will apply. Please see Section 2 for information on participation.

Benefit Option	Coverage Choices
Vision	<ul style="list-style-type: none"> • UnitedHealthcare Basic Vision • UnitedHealthcare Enhanced Vision
Life and Accidental Death & Dismemberment (AD&D) Insurance	<ul style="list-style-type: none"> • Basic Group Term Life Insurance • Basic AD&D Insurance • Additional Group Term Life Insurance • Additional AD&D Insurance
Long-Term Disability Insurance	<ul style="list-style-type: none"> • Basic Long-Term Disability Insurance • Long-Term Disability Buy-Up Insurance
Short-Term Disability Insurance	<ul style="list-style-type: none"> • Voluntary Short-Term Disability Insurance
Legal	<ul style="list-style-type: none"> • Legal Resources
Employee Assistance (Wellbeing Hotline)	<ul style="list-style-type: none"> • Aetna
Travel Assistance	<ul style="list-style-type: none"> • 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, do not constitute a contract of employment with the university and do not give you the right to be retained in the employment of the university. No one speaking on behalf of the Plan or the university can alter the terms of the Plan. You and your beneficiaries may obtain copies of this Plan document and SPD and the Benefit Descriptions, or examine these documents by contacting the Plan Administrator at the number and address set forth in Section 6 below.

Throughout this document, you will be referred to a dedicated call center that is available to assist you with any questions or concerns that you may have about your benefit options, which you can reach by calling (833) 698-0324 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

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

Benefits-Eligible Employee – Any individual on the payroll of the university, and not paid by accounts payable, whose wages from the university are subject to withholding for the purposes of federal income taxes and the Federal Insurance Contributions Act. Except to the extent an individual who is listed below is determined by the university to be an “ACA Full-Time Employee,” the term Benefits-Eligible Employee will not include:

- a student, including a fellow, graduate teaching assistant or other person whose employment is incidental to his or her educational program, as determined by the university;
- a Faculty Member who is appointed on a temporary basis as a part-time lecturer or professorial lecturer of one semester (or less) or paid on a per-course basis;
- a nonresident alien with no U.S. source earned income (as that term is described in Code section 410(b)(3)(C));
- a leased employee;
- an individual whom the university classifies as a temporary employee, independent contractor, contract worker, casual employee, or consultant (regardless of the individual’s employment status under applicable law);
- any person who is regularly scheduled to work less than 14 hours per week;
- a Postdoctoral Associate (except with respect to the Employee Assistance Benefit Option and the Travel Assistance Benefit Option);²
- a Postdoctoral Scholar (except with respect to the Employee Assistance Benefit and the Travel Assistance Benefit Option);² or
- any person excluded from participation under the terms of the Benefit Descriptions.

Effective on and after June 1, 2017, a Benefits-Eligible Employee shall include a Tenured Faculty Member who is enrolled in the Plan, approved for Long-Term Disability Insurance Benefits and remains

² For more information on benefit for Postdoctoral Associates and Postdoctoral Scholars, visit http://hr.gw.edu/postdoc_benefits.

on an unpaid leave of absence from the university.

Faculty Member –

- **Full-Time Faculty Member** – A Benefits-Eligible Employee who is appointed for at least one academic year in one of the regular, specialized (e.g. research and special service faculty), or visiting ranks listed in the Faculty Code and who devotes 100% effort to the duties of the position, and who receives a salary through the university. Faculty appointed on a temporary basis (one semester or less) are not included. Full-Time Faculty Member also includes a Partial Retiree as provided in the Faculty Code, which is a Benefits-Eligible Employee who is a Full-Time Faculty Member who reduces their workload to either a two-thirds or a half-time basis. Such Partial Retiree will continue to be eligible for benefits as a Full-Time Faculty Member during the partial retirement period.
- **Part-Time Faculty Member** – A Benefits-Eligible Employee who is generally appointed for one academic year and who devotes less than 100% effort to university duties (with the exception of a Partial Retiree, described above under “Full-Time Faculty Member.”). Part-time faculty who are on one-semester appointments or who are compensated on a per-course basis are not included.
- **Tenured Faculty Member** – A Faculty Member who has been appointed and approved for tenure as provided in the university’s Faculty Code.

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

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

- **Full-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 40 hours per week.³
- **Part-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 14 hours a week but less than 40 hours per week.

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

Eligibility for Coverage

Only a Benefits-Eligible Employee and their eligible Dependents may receive Plan benefits.

For Medical Benefit purposes, both options 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. To

³ Benefits-Eligible Employees at the GW Biostatistics Center who work 35 or more hours per week are considered Full-Time Staff for purposes of benefits; those who work at least 14 but less than 35 hours per week are considered Part-Time for benefit purposes.

determine whether you are eligible to participate in a Benefit Option, please read the eligibility information contained in the following eligibility chart.

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 (such as the Plan’s Medical Benefit) before the Travel Assistance Benefit. For a Dependent child to be eligible for the Travel Assistance Benefit, the Dependent child must be unmarried and traveling with the Benefits-Eligible Employee. The Travel Assistance Benefit is only for travel on university business that is approved in advance by the International Programs office.

For complete information regarding eligibility, you should also refer to the underlying Benefit Descriptions available at <https://benefits.gwu.edu>.

Eligibility Chart for Faculty Members, Staff Members and Residents	
Benefit Option	Eligibility
Medical Benefit (including prescription drug) Dental Benefit Vision Benefit Employee Assistance Benefit Travel Assistance Benefit Legal Benefit	<p>Full-Time and Part-Time Faculty and Staff Members are eligible on the first of the month following or coincident with their date of hire.</p> <p>Residents are eligible for Medical Benefits on their date of hire. Eligibility for remaining benefits is on the first of the month following or coincident with date of hire.</p> <p>ACA Full-Time Employees that are not otherwise Benefits-Eligible Employees are eligible for Medical Benefits (GW Health Savings Plan (HSP) and Health Savings Account only) on the first day of the stability period that follows an applicable initial or on-going measurement period during which the individual meets the definition of “ACA Full-Time Employee” (as determined by the university) and any applicable administrative period.</p> <p>Postdoctoral Associates and Postdoctoral Scholars are eligible for the Employee Assistance Benefit Option and the Travel Assistance Benefit Option on the first of the month following or coincident with the commencement of their programs.</p>
Life and AD&D Insurance Benefit	<p>The following Benefits-Eligible Employees are eligible on the first of the month following or coincident with their date of hire:</p> <ul style="list-style-type: none"> • Full-Time and Part-Time Faculty Members • Full-Time Staff Members • Residents <p>Part-Time Staff Members are eligible on the first of the month following 6 months of continuous service.</p>

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

Dependents Eligible for Coverage

Benefits-Eligible Employees may enroll eligible Dependents in the Medical, Dental, Vision, Additional Life and/or AD&D Insurance (if you also select Additional Life and/or AD&D Insurance for yourself), and Legal Benefits. ACA Full-Time Employees that are not otherwise Benefits-Eligible Employees may enroll eligible Dependent children in the Medical Benefit (GW Health Savings Plan (HSP) only). Dependents are automatically covered for Employee Assistance Benefits and for Travel Assistance Benefits when unmarried and traveling with a Participant.

Eligible Dependents include:

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

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

In order to cover your eligible Dependents, you must submit documentation verifying that they are

eligible under the Benefit Option rules. Shortly after you enroll a Dependent(s), you will receive an email from GW Benefits with full details on what documentation is required, when it must be provided, and where to send it. Your Dependent(s) will not be covered until the Plan Administrator receives this required documentation. If you fail to provide the required documentation within 30 calendar days of your date of eligibility, your Dependent(s) will not be enrolled.

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

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

The university reserves the right to audit Dependent eligibility at any time. Dependents whose eligibility is not timely verified will be terminated from the Plan immediately. Participants who maintain an ineligible Dependent or Dependents on the Plan may be penalized. 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 GW Coverage

No individual may be enrolled as both a Participant and a Dependent under any Benefit Option in this Plan and/or the Health and Welfare Benefit Plan for Retired Employees, and no individual may be covered as a Dependent by more than one Participant.

If a Covered Dependent Becomes Ineligible for Coverage

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

Dissolution of Domestic Partnership or Civil Union

Within 30 calendar days following the dissolution of a Domestic Partnership or Civil Union, you must provide 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.

Enrolling in the Plan: Initial Eligibility

You must enroll within **30 calendar days** of the date you and/or your Dependent(s) become eligible (which is often 30 calendar days following your date of hire). You must use the GW Benefits Enrollment System, which can be accessed at go.gwu.edu/enroll4benefits, to make elections for a Benefit Option of the Plan, or other process the Plan Administrator requires. You can't participate in the Plan until you enroll in accordance with procedures set forth by the Plan Administrator. If you do not enroll within this initial eligibility period, you will not have another opportunity to enroll until the open enrollment period, or after a qualifying life event. The university will notify you when the open enrollment period begins and ends.

When Evidence of Insurability (EOI) is Required

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

Optional Life Insurance EOI

As a new hire (or newly eligible employee), you can elect Optional Employee Life Insurance coverage up to the guaranteed issue amount without EOI. Amounts elected above the guaranteed issue amount will require EOI and you and your Spouse/Domestic Partner will be enrolled at the guaranteed issue amount until the EOI is approved.

For employees, the guaranteed issue amount is \$500,000. For your Spouse/Domestic Partner, the guaranteed issue amount is the lesser of \$50,000 or 50% of your optional employee life insurance.

Guaranteed Issue and Family Status Changes: If you experience certain family status changes, you may newly elect or increase optional employee life coverage up to the guaranteed issue of \$500,000 and spouse/domestic partner life coverage up to the guaranteed issue of \$50,000 without EOI as long as coverage has not been previously denied. Any amount elected over the guaranteed issue will require EOI.

Guaranteed Issue and Open Enrollment: During Annual Open Enrollment, you may newly elect or increase optional employee life coverage by \$250,000, up to \$500,000 without EOI as long as coverage has not been previously denied. Employees can also elect Optional Spouse or Domestic Partner Life Insurance coverage up to \$50,000, without EOI, as long as coverage has not been previously denied due to EOI.

Voluntary Short-Term Disability Insurance EOI

If you do not enroll in voluntary short-term disability insurance when you are first eligible or after certain family status changes (such as marriage, birth, adoptions, divorce, change in employment status) and elect coverage for the first time at a later date, including open enrollment, then you may be required to provide EOI at that time.

Open Enrollment

Each year there will be an annual open enrollment period during which you will be allowed to make changes to your benefit elections. The 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 online during open enrollment, then your previous benefit elections under the Plan will carry over to the next year.⁴

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

Changing Your Benefits During the Year

Assuming you are still eligible for benefits and you experience a qualifying life event, you can make changes outside of open enrollment within 30 calendar days of a qualifying life event. Generally, changes must be on account of, and correspond with, the life events described in the following table. You must elect changes in accordance with procedures set forth by the Plan Administrator. Call the Benefits Call Center at (833)698-0324 or call/email GW Benefits at (571) 553-8382/benefits@gwu.edu for additional information.

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

⁴ Please note that certain other benefit programs that are not described in this SPD, such as Flexible Spending Accounts, require you to affirmatively elect to continue the benefit during each open enrollment period; otherwise the benefit will not be carried over into the new Plan year. For more information, please visit <https://benefits.gwu.edu>, or call (888) 4GWUBEN (449-8326).

QUALIFYING LIFE EVENTS

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

QUALIFYING LIFE EVENTS

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

QUALIFYING LIFE EVENTS

Family Status Change	Add Employee	Add Spouse/ Partner	Add Child	Drop Employee	Drop Spouse/ Partner	Drop Child	Required Documentation
Reduction in Hours Below 30****	NO	NO	NO	YES	YES	YES	Proof of Enrollment in Another Plan that Provides Minimum Essential Coverage
Enrollment in Medical Coverage through a Health Insurance Marketplace****	NO	NO	NO	YES	YES	YES	Proof of Enrollment in Another Plan that Provides Minimum Essential Coverage

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

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

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

**** Medical Benefit only.

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 on the GW Benefits Enrollment System, which can be accessed at go.gwu.edu/enroll4benefits. (If you are adding or dropping a Dependent due to a divorce or legal separation or due to the events described under “Special Enrollment Rights,” below, you have 60 calendar days to report the event.) You will be asked to submit any necessary documentation (as applicable) related to the qualifying life event. However, do not wait until you receive documentation before enrolling; you must report the event within 30 calendar days of the event or it will be treated as a late enrollment and you will be required to wait until the next open enrollment period.

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

Effective Date of Change

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

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

In the event of a change in your employment status (such as moving from full-time to part-time, or going on certain types of leave of absence as described beginning on page 32 of this SPD), your new benefit elections will take effect on the first day of the month following or coincident with the event, provided you submit all required documentation. If returning from leave under the Family and Medical Leave Act, your allowable changes to benefits elections will be effective on the date you return to work.

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

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

Special Enrollment Rights

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

Newly Eligible Dependents

If you decline enrollment for yourself or your Dependents (including your Spouse/Partner) and later acquire a Dependent as a result of marriage, birth, adoption, or placement for adoption, then you may be able to enroll yourself and your Dependents in the medical, dental and vision coverage. You must request enrollment no later than 30 calendar days following the marriage, and 60 calendar days following the birth, adoption, or placement for adoption.

Please note that newborns are not automatically added to your coverage; you must take action for coverage to be effective. If you enroll a new child within 60 calendar days of the birth, adoption, or placement for adoption, then the child's coverage will be retroactive back to the birth, adoption, or placement for adoption. If you enroll a child after 60 calendar days, then coverage will begin on the first of the month following the university's receipt of enrollment. You must provide supporting documentation when enrolling the child; however, **do not wait to enroll your child until you receive the child's social security number or birth certificate; you may submit other proof of birth, adoption, or placement for adoption.**

Other Special Enrollment Rights

If you or your Dependent (1) loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP")⁵ as a result of a loss of eligibility for such coverage or (2) becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you will be able to enroll yourself and your Dependents in Health Coverage provided that a request for enrollment is made within 60 calendar days after the loss of such coverage or premium assistance eligibility.

To request special enrollment or obtain more information visit the GW Benefits Enrollment System, which can be accessed at go.gwu.edu/enroll4benefits, or contact the call center (833) 698-0324 or <https://hr.gwu.edu/benefits>.

When Participation Ends

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

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

- the Plan terminates;
- your employment with the university is terminated;⁶
- you are laid off or go on strike; or
- you cease to satisfy the definition of Benefits-Eligible Employee.

Your participation in a Benefit Option or Medical Benefit option will end on the earlier of the date:

- you cease participating in the Plan;
- you cease to satisfy the definition of ACA Full-Time Employee;⁷

⁵ The Children's Health Insurance Program (CHIP) provides free or low-cost health coverage for children up to age 19. Children in families with incomes up to \$82,268/year (for a family of four) are likely to be eligible for coverage. In many states, families can have higher incomes and their children can still qualify. Call 1-877-KIDS-NOW (1-877-543-7669) for more information about CHIP.

⁶ Note: The termination date for nine-month faculty who are not returning to the university for the fall semester is May 31.

⁷ The coverage of an employee who is otherwise not considered a Benefits-Eligible Employee under the Plan but was offered

- you discontinue participation in a Benefit Option or Medical Benefit option during open enrollment;
- you fail to make a contribution required for a Benefit Option or Medical Benefit option;
- you go on certain types of leave of absence during which continued participation is not authorized by the terms of the Benefit Option (see “Special Situations,” beginning on page 31); or
- you cease to satisfy the conditions of a Benefit Option or Medical Benefit option.

Notwithstanding the foregoing, the university may, in its sole discretion, cause your (or your Dependents’) coverage under the Plan or a Benefit Option to terminate if you or your Dependent: provides false information or makes misrepresentations in connection with enrollment or a claim for benefits; permits an unauthorized person to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts, or omissions.

Your Dependent’s participation in the Plan or a Benefit Option ends when your coverage ends or when your Dependent 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. In addition, you should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights after coverage ends.

If you are Rehired

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

- **Medical Benefits:** If you are rehired within 365 calendar days of your termination date, your previous benefits eligible service will apply toward any applicable waiting period. If you are rehired within 30 calendar days of your termination date, you may not change your election from the previous employment period. However, you may modify your elections if you experienced a qualifying life event or if a new Plan year has begun.
- **Life and AD&D Insurance:** If you are rehired within 365 calendar days of your termination date, your previous benefits eligible service will apply toward the waiting period. You may newly elect coverage up to the Guaranteed Issue (GI) without Evidence of Insurability (EOI). Elections over the GI will require EOI.

coverage under a Medical Benefit option solely on the basis of achieving “full-time employee” status under the Affordable Care Act and not the Plan’s general eligibility rules, will terminate on the last day of the stability period for which the covered employee was determined to be an ACA Full-Time Employee during a preceding measurement period (as determined by the university in accordance with Treas. Reg. § 54.4980H-3).

- **Voluntary Short-Term Disability Insurance:** If you are rehired within 365 calendar days of your termination date, your previous benefits eligible service will apply toward the waiting period. You may elect new coverage without EOI.
- **Long-Term Disability Buy-Up Insurance:** If you are rehired within 365 calendar days of your termination date, your previous benefits eligible service will apply toward the waiting period. For a period of 30 calendar days, you may elect the same coverage you had during your previous employment period. You cannot make any further changes for the remainder of the plan year, absent a family status change.

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 13.

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

Available Options

For Benefits-Eligible Employees (see “Eligibility for Coverage” section beginning on page 8)		
Benefit Option	Explanation	Cost Sharing
Medical (including prescription drug)	<p>You can elect to participate in one of the available Medical Benefit options or waive coverage. Each 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). Copayments and coinsurance amounts vary between plans, and within plans in each tier. You can choose employee only, employee + Spouse/Partner, employee + child(ren) (this includes you plus one or more children) or employee + family (this includes you, plus a Spouse/Partner and at least one other Dependent).</p> <p>Depending on which Medical Benefit option you pick, you may also be eligible to establish and contribute to a health savings account and receive university matching contributions to your health savings account, up to annual IRS limits. Consult your Flexible Benefits Plan Summary Plan Description for additional information about health savings accounts.</p> <p>Medical Benefit Participants automatically receive the prescription drug coverage through CVS Caremark.</p>	You and the university share the cost of coverage. Your portion of the cost is paid with pretax contributions.
Dental	You can elect to participate in one of the available Dental Benefit options or waive coverage. You can choose employee, employee + one, or employee + family coverage. The Dental Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option.	You pay the full premium with pretax contributions.
Vision	You can elect to participate in one of the available Vision Benefit options or waive coverage. You can choose employee, employee + one, or employee + family coverage. The Vision Benefit is a stand-alone Benefit Option so you can choose coverage whether or not you enroll in a Medical Benefit option.	You pay the full premium with pretax contributions.

For Benefits-Eligible Employees

(see “Eligibility for Coverage” section beginning on page 8)

Benefit Option	Explanation	Cost Sharing
Employee Assistance	You and your Dependents are automatically covered for counseling services. There is no need to affirmatively elect this benefit during the open enrollment period or at any other time.	The university pays the full premium.
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 premium.
Legal	You can elect to participate in the Legal Benefit in order to help protect yourself against high legal fees. You, your Spouse/Partner, and children will have access to professional attorneys nationwide. With this benefit, certain services are covered at 100%, and you receive a 25% attorney fee discount for other services. Note that you may not cancel your enrollment in this benefit until you have participated for at least 12 months.	You pay the full premium with after-tax contributions.
Life and/or AD&D Insurance	<p><i>Basic Life and AD&D Insurance</i></p> <p>You automatically receive Basic Life and AD&D Insurance Benefit coverage equal to one times your Benefits Salary not to exceed \$500,000. The IRS considers the cost of any life coverage exceeding \$50,000 “imputed income” that the university will report on your IRS Form W-2 as part of your taxable compensation. Thus, if your Benefits Salary exceeds \$50,000, you may elect to waive Basic Life Insurance Benefit coverage over \$50,000. However, if you later decide to change this election, you will need to provide Evidence of Insurability (EOI) at that time. See page 11 for an EOI explanation.</p> <p>In addition, a special death benefit of one month’s Benefits Salary is paid by GW to your beneficiary if you die while an active employee.⁸</p> <p>It is important to designate a beneficiary to receive your Life Insurance Benefits. Please be sure to periodically review and update your beneficiary designation as necessary.</p>	The university pays the full premium for Basic Life and AD&D Insurance Benefits.

Note: At age 70, age reductions apply to the coverage amounts described here. See the Benefit Description for details.

⁸The special death benefit is subject to forfeiture or clawback if it is determined by the university in its sole discretion that employee engaged in fraud, malfeasance, misappropriation, or other conduct detrimental to the university or its reputation.

For Benefits-Eligible Employees

(see “Eligibility for Coverage” section beginning on page 8)

Benefit Option	Explanation	Cost Sharing
	<p><i>Additional Life and/or AD&D Insurance</i></p> <p>You can elect optional Additional Life and/or AD&D Insurance Benefit coverage in increments of \$10,000 up to the lesser of five times your Benefits Salary or \$1,000,000. You can also waive coverage. If you later decide you want to elect an increased coverage amount, you will need to provide Evidence of Insurability (EOI) at that time. See page 11 for an EOI explanation.</p> <p>It is important to designate a beneficiary to receive your Life Insurance Benefits. Please be sure to periodically review and update your beneficiary designation as necessary.</p>	<p>You pay the full premium for any Additional Life and/or AD&D Insurance Benefit coverage you elect with after-tax contributions.</p>
	<p><i>Dependent Life and/or AD&D Insurance</i></p> <p>If you elect optional Additional Life and/or AD&D Insurance Benefit coverage, you can elect optional Dependent Life and/or AD&D Insurance Benefit coverage for your Spouse/Partner and/or eligible Dependent children. You can elect Additional Life and/or AD&D Insurance Benefit coverage for your Spouse/Partner in increments of \$5,000 up to the lesser of 50% of your coverage or \$500,000. You can elect Additional Life and/or AD&D Insurance Benefit coverage for your children (up to age 26) in increments of \$2,000 up to the lesser of 50% of your coverage or \$20,000, except that additional coverage is limited to \$1,000 for children up to age six months. You can also waive coverage for your Dependents. If you later decide you want to elect an increased coverage amount for your Spouse/Partner, you will need to provide Evidence of Insurability (EOI) at that time. See page 11 for an explanation of EOI and other requirements.</p>	<p>You pay the full premium for any Dependent Life and/or AD&D Insurance Benefit coverage you elect with after-tax contributions.</p>
<p>Long-Term Disability Insurance</p>	<p>If you are a Full-Time Staff Member or Full-Time Faculty Member, then you automatically receive Basic Long-Term Disability Insurance Benefit equal to 60% of your monthly Benefits Salary, up to \$10,000 per month, minus income from other sources. You also have the option to elect a higher level of coverage with the Long-Term Disability Buy-Up Insurance. Pre-existing condition exclusions apply to both levels of coverage in the first 12 months after your effective date of coverage and are detailed in the Benefit Description.</p>	<p>The university pays the full premium for Basic Long-Term Disability Insurance Benefit coverage, and you pay the full premium for the Long-Term Disability Buy-Up Insurance with after-tax contributions.</p>

For Benefits-Eligible Employees		
(see “Eligibility for Coverage” section beginning on page 8)		
Benefit Option	Explanation	Cost Sharing
Voluntary Short-Term Disability Insurance	<p>Part-Time Faculty and Staff Members, and Full-Time Faculty and Staff Members with less than two years of benefit-eligible service* who elect Voluntary Short-Term Disability Insurance and who are unable to work because of a non-occupational disability may receive income replacement equal to 60% of their monthly Benefits Salary up to \$3,000 per week for up to 22 weeks after satisfying the 14-day elimination period. Once you become eligible for GW-paid short-term disability coverage, your coverage in the Voluntary Short-Term Disability Insurance will end and your premiums will stop. For more information about GW-paid short-term disability insurance, please visit https://hr.gwu.edu/benefits.</p> <p>* Benefit-eligible service means you are in a benefit eligible position.</p>	<p>You pay the full premium for Voluntary Short-Term Disability Insurance with after-tax contributions.</p>

Your Contributions

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

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

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

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

Definition of “Dependent” for Tax Purposes

The Internal Revenue Code treats the cost of coverage for Spouses, including common law spouses, and biological children or children acquired through marriage as exempt from taxes. For any other covered Dependent, a payment for health benefit coverage is not exempt from tax unless the person is a “qualified tax dependent” as defined in the Internal Revenue Code. Under the definition in section 152

of the Internal Revenue Code, a qualified tax dependent must be:

1. A member of your household 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 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 his or her children as Dependents for tax purposes before you certify that they are tax qualified Dependents.

Contributions for Your Non-Qualified Tax Dependents

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

If Non-Qualified Tax Dependents are Covered for Medical Benefits		
Who is Covered	Premium Paid by Employee (Pretax Contribution)	Imputed Income
<ul style="list-style-type: none"> • Employee • Partner 	Employee contribution for Employee + Spouse/Partner coverage	Cost to the Plan of Employee Only coverage
<ul style="list-style-type: none"> • Employee • Partner • Employee's Dependent child(ren) 	Employee contribution for Employee + Family coverage	Cost to the Plan of Employee Only coverage

If Non-Qualified Tax Dependents are Covered for Medical Benefits

Who is Covered	Premium Paid by Employee (Pretax Contribution)	Imputed Income
<ul style="list-style-type: none"> • Employee • Partner • Partner's child(ren) 	Employee contribution for Employee + Family coverage	Cost to the Plan of Employee + Child(ren) coverage for medical and cost of family coverage for other benefits.
<ul style="list-style-type: none"> • Employee • Partner • Employee's Dependent child(ren) • Partner's child(ren) 	Employee contribution for Employee + Family coverage	Cost to the Plan of Employee + Child(ren) coverage for medical and cost of family coverage for other benefits.

SECTION 4

COBRA

Your Right to Continue Coverage – COBRA

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

Although the law does not require the university to offer continuation coverage to a Partner or their children (a “non-qualified tax dependent,” as explained on page 25) upon the loss of coverage, the university offers the continuation of their Health Coverage on the same basis as COBRA.

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

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

COBRA Qualifying Event	COBRA Maximum Coverage Duration (Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below.)
Termination of employment (for any reason other than gross misconduct)	18 months (Benefits-Eligible Employee and covered Dependents); may be extended to 29 months if a qualified beneficiary is disabled ⁸
Reduction in the Benefits-Eligible Employee's hours worked, or the Benefits-Eligible Employee goes on an approved leave of absence during which Health Coverage ends	18 months (Benefits-Eligible Employee and covered Dependents); may be extended to 29 months if a qualified beneficiary is disabled ⁹
Death of the Benefits-Eligible Employee	36 months (surviving covered Dependents)

⁹ To be eligible for the 11-month extension, the disabled qualified beneficiary must have been determined to have been disabled during the first 60 calendar days of COBRA coverage and written notice of such determination must be provided to GW Benefits or bswift within 60 calendar days of the date of the determination and before the original 18-month COBRA period expires.

COBRA Qualifying Event	COBRA Maximum Coverage Duration (Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below.)
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

Other Information

The university contracts with bswift to handle COBRA administration, billing, and premium collection. An application for continued benefits under COBRA must be returned directly to bswift at the address listed in Section 8: Service Provider Directory. You may also enroll online at Go.gwu.edu/COBRA. You and/or your Dependents may elect to continue coverage under the Health Coverage in which you and/or they were enrolled at the time the COBRA Qualifying Event occurred. You must make your election within 60 calendar days of the COBRA event or receipt of the COBRA notice, whichever is later.

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

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

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

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

- Failure to pay the applicable premium by the due date;

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

Where You Can Learn More

You can contact the COBRA administrator at (866) 365-2413 or GW Benefits at (571) 553-8382 or <https://hr.gwu.edu/benefits> for additional information on COBRA. For more information about the Marketplace, visit <https://www.healthcare.gov>.

SECTION 5

Special Situations

Special Situations

This section describes special situations, such as a change in employment status or a leave of absence that may affect your eligibility for benefits under the Plan. You may be required to make elections in accordance with the process the Plan Administrator requires.

Change in Employment Status

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

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

If You Are On a Leave of Absence

The following paragraphs set forth the general rules regarding how typical paid and unpaid leaves of absence affect your benefits.

Unpaid Personal Leave of Absence

If you are on approved unpaid personal leave of absence during the Plan year, you can choose to continue your participation in the Medical, Dental, Vision, Employee Assistance, Travel Assistance, and Legal Benefits through the duration of your leave of absence, provided your premiums are paid. Your Basic and Additional Optional Life and/or AD&D Insurance Benefit coverage as well as your Voluntary Short-Term and Long-Term Disability Insurance Benefit coverage can only be continued for up to 12 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights after coverage ends. There is no portability or conversion for disability insurance.

If your unpaid leave of absence is 30 calendar days or less, your portion of the cost for benefits will accrue in arrears and be deducted from your pay upon your return to work. If your unpaid leave of absence exceeds 30 calendar days and you elect to continue your benefits, you will be responsible for remitting your share of the cost of the benefits directly to GW.

You may cancel your benefits within 30 calendar days of the start of your unpaid leave of absence through the GW Benefits Enrollment System at go.gwu.edu/enroll4benefits. You should also refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. Upon your return to active employment, you may re-enroll or make a change to your benefits consistent with a qualifying life event within 30 calendar days of returning to

work through the GW Benefits Enrollment System. If you return to work within 30 days of the start date of your leave and you re-enroll, then you must elect the same elections you had before the leave. However, you may modify your elections if you experienced a qualifying life event or if a new Plan year has begun.

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

If you are on approved, unpaid FMLA Leave or leave as an accommodation under the Americans with Disabilities Act (ADA), you may elect to continue your Medical, Dental, Vision, Employee Assistance, Travel Assistance, Legal, Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage through the duration of your leave of absence. If you are on approved Qualified USERRA Leave, you may elect to continue your Medical, Dental, Vision, Employee Assistance, Travel Assistance, and Legal benefit coverage through the duration of your leave of absence. Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage can only be continued up to 12 months of USERRA leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for disability insurance.

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

Note: If you are on FMLA Leave, leave under the ADA or Qualified USERRA Leave, your leave of absence may be paid, unpaid, or a combination of paid and unpaid depending on your accumulated paid time off balances. (Refer to the university’s Family and Medical Leave and USERRA Leave Policies.) If you remain in paid status during FMLA leave or Qualified USERRA Leave, your benefits premiums will be deducted from your pay as normal. If the cost of your benefits exceeds your pay during your leave, the remaining unpaid premium will accrue in arrears and be deducted from your paycheck.

You may cancel your benefits within 30 calendar days of the start of your unpaid leave of absence through the GW Benefits Enrollment System at go.gwu.edu/enroll4benefits. You should also refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. Upon your return to active employment, you may re-enroll or make a change to your benefits consistent with a qualifying life event within 30 calendar days of returning to work through the GW Benefits Enrollment System. If you return to work within 30 days of the start date of your leave and you re-enroll, then you must elect the same elections you had before the leave. However, you may modify your elections if you experienced a qualifying life event or if a new Plan year has begun.

Other Leaves of Absence

If you are on a paid administrative leave or suspension, your Medical, Dental, Vision, Legal, Employee Assistance and/or Travel Assistance benefit coverage will continue through the duration of your leave of

absence. Deductions from your pay will continue as normal. Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Short-Term Disability Insurance and Long-Term Disability Insurance can only be continued up to 12 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for disability insurance.

If you are on an involuntary, unpaid, administrative leave or suspension, your Medical, Dental, Vision, Legal, Employee Assistance and/or Travel Assistance benefit coverage will continue through the duration of your leave of absence as long as premiums are paid. Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Short-Term Disability Insurance and Long-Term Disability Insurance Benefit can only be continued up to 12 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for disability insurance.

If you are a Medical Resident on research assignment, you may elect to continue your Medical, Dental, Vision, Employee Assistance, Travel Assistance and Legal benefit coverage through the duration of your leave of absence as long as premiums are paid. Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage can only be continued up to 24 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for disability insurance.

If you are on a leave of absence for the purpose of either full-time study for an advanced degree, or work in the field of education or research such as a Fulbright Award, foundation grant, government project, or other academic research related to your field of expertise, you may elect to continue your Medical, Dental, Vision, Employee Assistance, Travel Assistance and Legal benefit coverage through the duration of your leave of absence as long as premiums are paid. If your leave of absence is paid, deductions from your pay will continue as normal. Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Short-Term Disability Insurance, and Long-Term Disability Insurance Benefit coverage can only be continued up to 24 months of leave. You should refer to the Benefit Descriptions for Life and AD&D Insurance Benefit coverage to learn more about your portability and conversion rights. There is no portability or conversion for disability insurance.

If You Return from a Leave of Absence

If your benefit coverage ends or you are not eligible for coverage during a leave of absence, you must take action to re-enroll in your Benefit Options within 30 calendar days of your return to work, or wait for the next open enrollment to re-enroll. You will not be automatically re-enrolled. If you return to work within 30 days of the start date of your leave and you re-enroll, then you must elect the same elections you had before the leave. However, you may modify your elections if you experienced a qualifying life event or if a new Plan year has begun.

If You Are On Disability

During Short-Term Disability

If you are approved for GW paid short-term disability benefits, your Medical, Dental, Vision, Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Basic Long-Term Disability Insurance, Long-Term Disability Buy-Up Insurance, Employee Assistance, Travel Assistance and Legal benefit coverage will continue through the duration of your leave of absence. Deductions from your pay for benefits premiums will continue as normal. If you are approved for voluntary short-term disability benefits, your Medical, Dental, Vision, Basic Life and AD&D Insurance, Optional Life and/or AD&D Insurance, Basic Long-Term Disability Insurance, Long-Term Disability Buy-Up Insurance, Employee Assistance, Travel Assistance and Legal benefit coverage will continue through the duration of your leave of absence provided your premiums are paid. If your voluntary short term disability leave exceeds 30 calendar days and you elect to continue your benefits, you will be responsible for remitting your share of the cost of the benefits directly to GW.

During Long-Term Disability

Applying for and receiving long-term disability (LTD) benefits does not mean that you are on approved, job-protected leave. You must apply for leave under applicable university policies.

Tenured Faculty Members

If you are a Tenured Faculty Member approved for long-term disability benefits, you may continue your coverage under the Plan for the duration of your approved long-term disability benefit. If you have Medical, Dental and/or Vision Benefit coverage when you qualify for long-term disability benefits, you pay the same cost as active employees. . The university will continue to pay the full premium for your Basic Life and AD&D Insurance Benefits, Employee Assistance and Travel Assistance. You will be responsible for paying the premiums for any Optional Life and/or AD&D Insurance Benefits you elect for yourself and your Dependents. Please refer to your Benefit Descriptions for more information about applying for the waiver of any Basic and Optional Life Insurance Benefit premiums after satisfying the applicable conditions. If you elected the Long-Term Disability Buy-Up Insurance, your premium will be waived once your long-term disability benefit has been approved. Finally, you may elect to continue your coverage under the Legal Benefit through the duration of your approved long-term disability benefits as long as you continue to pay the premium for the coverage. Please keep in mind that the university reserves the right to change this cost-sharing structure in the future or to eliminate coverage entirely.

Non-Tenured Faculty Members and all Staff Members

If you are a non-Tenured Faculty Member or Staff Member receiving long-term disability (LTD) benefits on or after June 1, 2017, and are not in a leave status affirmatively approved by the university as of the date you begin to receive LTD benefits, your employment with the university is terminated as of that date and your participation in the Plan will end at the end of the month in which you are terminated. If you meet the eligibility requirements of the Health and Welfare Plan for Retired Employees in effect on your termination date, then you and your Dependents have the opportunity to elect coverage as provided in the Health and Welfare Plan for Retired Employees at that time.

All determinations as to your eligibility for retiree coverage will be made in accordance with the university's Health and Welfare Plan for Retired Employees at your retirement. After your termination,

long-term disability (LTD) benefits will continue to be paid (without requiring the payment of premiums), provided you continue to be “disabled” and meet all other requirements of the underlying Benefit Description and insurance policy.

Under the Basic Life, Optional Life, and AD&D Life Insurance benefit options, the amount of coverage in effect on the day before your disability may continue without payment of premiums until the end of your disability (or age 60, if earlier). You must apply to, and receive approval from, the insurance carrier for a waiver of premiums due to disability as defined by the insurance carrier. Please refer to your Benefit Description for more information about the waiver of Basic Life, Optional Life, and AD&D Insurance Benefit premiums.

All other coverages under the Plan end upon your long-term disability.

If You Retire

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

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

If You Are Re-employed

If you are retired and eligible for benefits under the university’s Health and Welfare Plan for Retired Employees, then that coverage will cease if you are re-employed by the university in a Benefits-Eligible Employee position and you will again be eligible for coverage under this Plan. You will be required to contribute to your coverage under the same guidelines as an active employee with the same job title. If you return to work within 30 days of your retirement and you re-enroll, then you must elect the same elections you had before retirement. However, you may modify your elections if you experienced a qualifying life event or if a new Plan year has begun.

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

SECTION 6

Administrative Information

Introduction to Administrative Information

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

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

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

Plan Administration Committee
The George Washington University
45155 Research Place, Suite 160
Ashburn, VA 20147
(571) 553-8324

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

If you have any questions about your benefits, contact 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, and Plan identification number, which is 508.

Plan Year

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

Agent for Service of Legal Process

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

Corporation Service Company
1090 Vermont Ave., N.W.
Washington, DC 20005

Not a Contract of Employment

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

Plan Continuation

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

Plan Funding

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

Your Rights as a Plan Participant

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 calendar days, you may file

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact 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

No Pre-existing Condition Exclusions

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

No Rescission of Coverage

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

No Lifetime or Annual Limits

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

Patient Protections

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

Preventive Services

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

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

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

Clinical Trials

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

trial. For purposes of this provision, the terms “qualified individual,” “life threatening disease or condition,” approved clinical trial” and “routine patient costs” has the same meaning as found in section 2709 of the Public Health Services Act.

Cost Sharing

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

Wellness Incentives

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

Mental Health Parity

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

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

restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

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

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

Hospital Stays for Maternity

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

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

Women's Health and Cancer Rights Act Notice

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

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

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

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

If you are eligible for health coverage from the university, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium

assistance programs. You can contact 1-877-KIDS NOW or <https://www.insurekidsnow.gov> to find out how to apply.

Health Insurance Marketplace

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

No Surprises Act

The No Surprises Act (the “NSA”) protects you from receiving certain unexpected balance bills. Balance billing occurs when an out-of-network provider bills a patient directly for the difference between what the Plan pays and the full amount charged for the service provided by the out-of-network provider.

Beginning January 1, 2022, you are protected from surprise, or unexpected, balance bills, for:

- Out-of-network Emergency Services. If you have an Emergency Medical Condition and get Emergency Services from an out-of-network provider or facility, the most the provider or facility may bill you is your in-network cost-sharing amount (such as deductibles, copayments and coinsurance). This applies to services you may receive after you are in stable condition, unless you consent in writing to balance billing.
- Certain out-of-network services (emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist service) provided by out-of-network providers as part of a visit to an in-network facility. You can’t be asked by these providers to give up your protections with respect to these services. If you get other services at an in-network hospitals or ambulatory surgical centers, out-of-network providers can’t balance bill you unless you give written consent.

Additionally, health care providers and facilities must provide easy-to-understand notices explaining these billing protections and contact information for concerns about NSA violations.

If you believe you’ve been wrongly billed, you may contact the Claims Administrator. You may also contact the U.S. Department of Health and Human Services by calling 1-800-985-3059 or visiting <https://www.cms.gov/nosurprises/consumers>. You may also visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal

law.

Continuity of Care

If a participating provider leaves the provider network, a Continuing Care Patient who is receiving care with that provider will receive notification of the provider's change in network status and the Continuing Care Patient and may continue to receive care at the same in-network co-payment for up to 90 days after the later of the provider leaving the network or the date you are notified of the change.

You are a "Continuing Care Patient" for purposes of this section if you are:

- Undergoing a course of treatment for a serious and complex condition, defined as (a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time;
- Undergoing a course of institutional or inpatient care;
- Scheduled to undergo nonelective surgery (including postoperative care);
- Pregnant and undergoing a course of treatment for the pregnancy;
- Determined to be terminally ill and receiving treatment for such illness.

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 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 self-only or Dependent coverage, whether a participant is entitled to change 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 8. 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 his or her an authorized representative of a Participant or beneficiary 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 8 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 to process the claim, you will be given an opportunity to provide the missing information.

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

Claims and Appeals Procedures

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

Decision On A Claim

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

Urgent Care Claims

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

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

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

Other Claims (Pre-Service and Post-Service)

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

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

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

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

Ongoing Course of Treatment

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

Notice of Claim Denial

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

Appeal Procedure

If a claim is denied, you may write to the claims administrator for a review of the claim on appeal. You must request the review on appeal in writing within 60 calendar days after the claim is denied. If you fail to submit an appeal request within the 60-day period, you will have no further right to appeal.

As part of the appeal review procedure, you will be allowed to:

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

Standard Appeals

You have the right to file an appeal from an adverse benefit determination relating to service(s) you have received 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, and will allow you no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of urgent care claims, in which event you will be provided no less than two (2) days to respond to the new evidence or rationale.

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

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

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

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

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

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

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

No Conflict of Interest

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

Medical Claims – Voluntary External Appeals

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

External Review

“External review” is a review of an adverse benefit determination or a final internal adverse benefit determination by an independent review organization/external review organization (ERO) or by the state insurance commissioner, if applicable. You must complete the first level of standard appeal described under “Standard Appeals” before you can request external review, other than in a case of “deemed exhaustion.” External review is only available if your claim involves (1) medical judgment (excluding those claims that involve only contractual or legal interpretation without any use of medical judgment) as determined by the ERO, or (2) a rescission of coverage. An adverse benefit determination based upon your failure to meet the eligibility requirements under the plan isn't eligible for external review. External review is not available for claims under the Dental Benefit.

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

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

The notice of adverse benefit determination or final internal adverse benefit determination that you receive from the claims administrator will describe the process to follow if you wish to pursue an external review, and will include a copy of the request for external review form.

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

If you file a voluntary external appeal, any applicable statute of limitations, including the time limit set forth below under “Time Limit on Legal Proceedings,” will run while the appeal is

pending – it will not be tolled. The filing of a claim will have no effect on your rights to any other benefits under the medical coverage option. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

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

Request for External Review

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

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

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

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

Preliminary Review

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

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

Referral to an External Review Organization (ERO)

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

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

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

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

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

Upon receipt of a notice of a final external review decision reversing the adverse benefit

determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

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

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

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

Referral of Expedited Review to an External Review Organization (ERO)

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

Review of a Claim for No Surprises Act Services

You may also request external review for any adverse benefit determination relating to a No Surprises Act Service. You must file a request for external review of a denial of a No Surprises Act Service within four months of the date you received the final adverse benefit determination. The Plan will refer your appeal to an ERO. You will receive a decision from the ERO within 45 days of the ERO's receipt of your request for review.

Online Safety and Security

The university and Plan service providers follow legal and technical guidelines to protect your health and other confidential information online, but you can take some basic steps to protect your privacy and reduce the risk of fraud and loss to the Plan:

- Use strong, unique passwords when set up and log in to your accounts, and change your passwords regularly.
- Protect the confidentiality of your account passwords and related identifying information.
- Take advantage of dual-factor authentication where available.
- Monitor your accounts for unusual activity.
- Use only trusted Wi-Fi networks.
- Keep vendor applications current.
- Know what to do if you think your accounts have been compromised or your identity stolen.

For more information about the Plan's security efforts, see Appendix A, Privacy and Security of Health Information.

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 7

Glossary

- **ACA Full-Time Employee** – Any common-law employee of the university who is determined by the university to be employed an average of at least 30 hours of service per week. The university may use any method of determining ACA Full-Time Employee status as may be permitted under the Affordable Care Act, and may establish any permitted measurement period and administrative period. The determination method need not be the same for all employees and may be changed at the university’s discretion and to the extent permitted by the Affordable Care Act.
- **Affordable Care Act (ACA)** – The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education and Reconciliation Act of 2010, and the regulations and guidance issued thereunder.
- **Benefit Description** – A benefit booklet, group insurance policy, insurance contract, certificate of coverage, or other document specifying the terms, conditions, exclusions, and other rules for a Benefit Option provided pursuant to this Plan.
- **Benefit Options** – The various health and welfare benefits provided or made available to Participants by the university as set forth herein and incorporated hereunder.
- **Benefits-Eligible Employee** – Any individual on the payroll of the university, and not paid by accounts payable, whose wages from the university are subject to withholding for the purposes of federal income taxes and the Federal Insurance Contributions Act. Except to the extent an individual who is listed below is determined by the university to be an “ACA Full-Time Employee,” the term Benefits-Eligible Employee will not include:
 - a student, including a fellow, graduate teaching assistant or other person whose employment is incidental to an educational program, as determined by the university;
 - a Postdoctoral Associate or a Postdoctoral Scholar (except with respect to the Employee Assistance Benefit Option and the Travel Assistance Benefit Option);
 - a Faculty Member who is appointed on a temporary basis as a part-time lecturer or professorial lecturer of one semester (or less) or paid on a per-course basis;
 - a nonresident alien with no U.S. source earned income (as that term is described in Code section 410(b)(3)(C));
 - a leased employee;
 - an individual whom the university classifies as a temporary employee, independent contractor, contract worker, casual employee, or consultant (regardless of the individual’s employment status under applicable law);
 - any person who is regularly scheduled to work less than 14 hours per week; or
 - any person excluded from participation under the terms of the Benefit Descriptions.

- Effective on and after June 1, 2017, a Benefits-Eligible Employee shall include a Tenured Faculty Member who is enrolled in the Plan, approved for Long-Term Disability Insurance Benefits and remains on an unpaid leave of absence from the university.
- **Benefits Salary** - Your benefits salary is equal to the salary(ies) of your active benefit eligible primary and secondary positions. This Benefits Salary is used to determine salary driven contributions as well as plan coverages and premiums, as applicable. For purposes of calculating your Short Term Disability Insurance Benefit, Long-Term Disability Insurance Benefit, Life and AD&D Insurance Benefit, and Special Death Benefit, your Benefits Salary is your gross bi-weekly/monthly income from all benefits eligible positions from the university in effective just prior to your date of disability, injury or death. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, non-benefits eligible compensation, any other extra compensation, or income received from sources other the university.
- **CHIP** – The Children’s Health Insurance Program.
- **Civil Union** – A legally recognized union of a same-sex couple, with rights similar to those of marriage.
- **Civil Union Partner**– A partner of a Participant who has legally entered into a Civil Union pursuant to the applicable state’s law.
- **COBRA** – The Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, and any successor provisions thereto.
- **Dental Benefit** – The dental insurance benefit provided or made available to eligible Participants and their Dependents, as it may exist from time to time.
- **Dependent** – Unless otherwise specified in the Plan or the applicable Benefit Description, the term Dependent will include:
 - the legal Spouse (as defined by federal law) of the Participant, the common law Spouse of the Participant, the Partner of the Participant;
 - a Participant’s child (including stepchildren, children legally placed for adoption, legally adopted children, and children of a same-sex Partner) if such child is under age 26; provided, however, your Domestic Partner must also be enrolled in order to cover 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.
- **Emergency Medical Condition** -- A medical condition, including a mental and nervous disorder or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of a Participant (or her unborn child, if she is pregnant); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.
- **Emergency Services** -- Emergency Services generally means, with respect to an Emergency Medical Condition, an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as would be required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). "Emergency Services" includes items and services that are furnished by an out-of-network provider or out-of-network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after you are stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in this paragraph are furnished, unless all conditions of the No Surprises Act notice and consent provisions are met.
- **Employee Assistance Benefit** – The counseling services benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.
- **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.
- **Essential Health Benefits** – Health-related items and services that fall into the following categories, as defined in section 1302 of the Affordable Care Act and further determined by

the Secretary of Health and Human Services.

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

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

- **Evidence of Insurability (EOI)** – Proof showing you and/or your Dependents are in good health.
- **Faculty Code** – The written rules approved by the 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.

- **FMLA Leave** – An authorized leave of absence that is taken pursuant to the Family and Medical Leave Act of 1993, as amended, and/or similar applicable state or local family and medical leave laws.
- **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: (833) 698-0324, Fax: 571-553-8385, email: benefits@gwu.edu, website: <https://hr.gwu.edu/benefits>.
- **Health Coverage** – Medical, Dental, Vision, and Employee Assistance Benefits that are protected by COBRA.
- **Health and Welfare Plan for Retired Employees** – The George Washington University Health and Welfare Benefit Plan for Retired Employees maintained by the university, as it may be amended from time to time.
- **Health Insurance Marketplace or Marketplace** – An organization set up by a state or federal government to facilitate the purchase of health insurance in accordance with the Patient Protection and Affordable Care Act of 2010.
- **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.
- **Legal Benefit** – The legal services benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.
- **Life and AD&D Insurance Benefit** – The life insurance and accidental death and dismemberment insurance coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time.
- **Long-Term Disability Insurance Benefit** – The long-term disability insurance coverage provided or made available to eligible Participants, as it may exist from time to time.
- **Medical Benefit** – The medical and prescription drug benefit coverage provided or made available to eligible Participants and their Dependents, as it may exist from time to time. The university may make available a telemedicine service through enrollment in one or more of the available Medical Benefit options. The telemedicine service may provide a lower cost office visit for virtual consultations under such Medical Benefit option. Where available,

enrollment in the telemedicine service is automatic and made available to eligible Participants and Dependents enrolled in the applicable Medical Benefit option.

- **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.
- **No Surprises Act** – The No Surprises Act of the 2021 Consolidated Appropriations Act, and the regulations and guidance issued thereunder.
- **No Surprises Act Services** – The following services:
 - out-of-network Emergency Services;
 - out-of-network air ambulance services;
 - ancillary services as defined under the No Surprises Act and its implementing regulations (including anesthesiology, pathology, radiology, and diagnostic services) when performed by out-of-network providers at in-network facilities; and
 - services to treat a condition that is not an Emergency Illness performed by an out-of-network provider at in-network facilities for which the provider does not comply with the notice and consent requirements under the No Surprises Act and its implementing regulations.
- **Participant** – A Benefits-Eligible Employee who becomes a Participant pursuant to Section 2.
- **Partner** – A Domestic Partner or Civil Union Partner.
- **Plan** – The George Washington University Health and Welfare Benefit Plan provided for herein, as it may be amended from time to time.
- **Plan Administrator** – The George Washington University Plan Administration Committee.
- **Postdoctoral Associate** – A postdoc employed by the University who receives financial support in the form of a salary, paid by University payroll, that is typically funded by grants, contracts or departmental funds secured by a faculty mentor.
- **Postdoctoral Scholar** -- A postdoc who receives financial support in the form of a fellowship or stipend, issued by the University via accounts payable, on behalf of an external sponsor. Due to the requirements of the funding source, Postdoctoral Scholars cannot be and are not University employees.
- **Qualified Military Leave** – An authorized leave of absence that is taken pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

- **QMCSO** – A medical child support order that complies with Section 609 of ERISA and any state laws governing such orders.
- **Resident** – A Benefits-Eligible Employee who serves as a medical resident.
- **Short-Term Disability Insurance Benefit** – The short-term disability coverage provided or made available to eligible Participants, as it may exist from time to time. Also called Voluntary STD.
- **SPD** – Summary Plan Description – this document, together with any underlying Benefit Descriptions.
- **Spouse** – The legal Spouse of the Participant (whether opposite-sex or same-sex) as defined by the state in which such Participant married, whether or not the state in which the Participant resides recognizes that marriage; or the common law Spouse of the Participant as defined by the state law in which the Participant resides.
- **Staff Member** – A Benefits-Eligible Employee of the university who is a regular full-time or regular part-time, graded or ungraded employee, who is not classified as a Faculty Member.
 - **Full-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 40 hours per week.¹⁰
 - **Part-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 14 hours a week but less than 40 hours per week.
- **Tenured Faculty Member** - A Faculty Member who has been appointed and approved for tenure as provided in the university's Faculty Code.
- **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 Teladoc, Amwell, Optum Virtual Care, Doctor on Demand, and effective January 1, 2023, Walmart Virtual Care, 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

¹⁰ Benefits-Eligible Employees at the GW Biostatistics Center who work 35 or more hours per week are considered Full-Time Staff for purposes of benefits; those who work at least 14 but less than 35 hours per week are considered Part-Time for benefit purposes.

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 8

Service Provider Directory

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

SERVICE PROVIDER CONTACT INFORMATION

Benefit	Provider/Claims Administrator	Contact Information	Group / Identification Number (If Applicable)	Funding *
Medical – GW Health Savings Plan (HSP) – GW PPO Plan	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
Dental – High Option PPO – Low Option PPO – Dental Maintenance Organization (DMO)	Aetna	(877) 238-6200 Aetna Dental P.O. Box 14094 Lexington, KY 40512-4094 www.aetna.com	Group Policy Number: GP-622758	Insured

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

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

Benefit	Provider/Claims Administrator	Contact Information	Group / Identification Number (If Applicable)	Funding *
Vision – Basic – Enhanced	UnitedHealthcare	Customer Service: 800-638-3120 Provider Locator: 800-839-3242 UnitedHealthcare Vision Claims Department P.O. Box 30978 Salt Lake City, UT 84130 www.myuhcvision.com	Group Number: 730193	Insured
Life and AD&D Insurance – Basic – Additional	Lincoln Life Assurance Company of Boston	(888) 787-2129	Plan Number SA3-880-054582-01	Insured
Special Death Benefit	GW	571-553-8382 GW Benefits The George Washington University 45155 Research Place, Suite 160 Ashburn, VA 20147	Not Applicable	Self-Funded
Long-Term Disability Insurance – Basic – Buy-Up	Lincoln Financial	For new claims and leaves Intake Services: (800) 213-5609 For existing claims and leaves Disability Claims: (800) 210-0268 Leave Services: (888) 787-1751	Policy Number GD/GF3-880-054582-01	Insured

Benefit	Provider/Claims Administrator	Contact Information	Group / Identification Number (If Applicable)	Funding *
Short-Term Disability Insurance	Lincoln Financial	For new claims and leaves Intake Services: (800) 213-5609 For existing claims and leaves Disability Claims: (800) 210-0268 Leave Services: (888) 787-1751	Policy Number PD3-880-054582-01	Insured
Legal	Legal Resources™	800-728-5768 Legal Resources 2 Bethesda Metro Center Suite 1560 Bethesda, MD 20814 www.legalresouces.com	Not Applicable	Insured
Employee Assistance (Wellbeing Hotline)	Aetna	866-522-8509 TTY: 888-879-8274		Insured
COBRA	bswift	(866) 365-2413 bswift - The George Washington University PO Box 860620 Minneapolis, MN 55486-0620 Go.gwu.edu/COBRA	Not Applicable	Not Applicable
Health Savings Account Program; Health Care and Dependent Care Flexible Spending Accounts (FSA)	PayFlex	800-284-4885 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

Benefit	Provider/Claims Administrator	Contact Information	Group / Identification Number (If Applicable)	Funding *
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

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

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.

Beginning January 15, 2022, the Plan will cover the cost of over-the-counter COVID-19 diagnostic tests purchased at an in-network pharmacies, and up to \$12 toward the purchase of over-the-counter COVID-19 tests at other locations. The number of tests will be limited to 8 per person per month. You may be asked to attest that the tests are for your personal use, are not for employment purposes, are not reimbursed from another sources, and are not for resale. This benefit will be provided without regard to whether you have met your annual deductible, and will not impact your eligibility for the HSA.

III. Other Services

From the period of March 18, 2020, until September 30, 2020, the Plan will cover 100% of the costs of all telemedicine visits through Virtual Visits. 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, except as follows:

- HSP participants: Virtual Visits will be provided without copayment or deductible for the period beginning April 1, 2022, and ending December 31, 2022; and

- PPO participants: Virtual Visits will be provided without copayment or deductible for the period beginning July 1, 2022, and ending December 31, 2022.

An individual with coverage under the HSP may receive coverage for any Virtual Visit before satisfying the HSP's deductible and still contribute to an HSA from January 1, 2020, through December 31, 2021, and again from April 1, 2022, through December 31, 2022.

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).

V. Benefits During Severance Period

This section describes how becoming eligible for severance during the period beginning July 1, 2020, and ending August 11, 2021, will affect your benefits. If you are a Benefits-Eligible Employee who became eligible for severance during this period and who elected to receive the salary continuation benefit payable in periodic installments, you will continue to be a Benefits-Eligible Employee for the duration of the salary continuation benefit (also known as the “severance period”) with respect to the Medical (including prescription drug), Dental, Vision, Basic and Optional Life Benefit Options only, in accordance with these provisions. You are considered to be on “leave with severance pay” for the duration of the severance period. Deductions of your contributions for your benefit programs will be made from your severance payments.

When Participation Ends

For purposes of determining when your benefits end, your employment is considered terminated as of your elimination date if you elected to receive your salary continuation payment in the form of a lump sum. Participation for you and your covered Dependents in this Plan will cease on your elimination date or the end of the month in which your elimination occurs, in accordance with the terms of the applicable Benefit Description. If you elected to receive the salary continuation benefit in the form of periodic payments over the duration of the severance period, your employment termination date for benefits purposes is the last day of the severance period, and participation for you and your covered Dependents will cease on the last day of the severance period or the end of the month in which the last day of the severance period occurs, in accordance with the terms of the applicable Benefit Description.

You should refer to the Benefit Descriptions for Life Insurance Benefit coverage to learn about your portability and conversion rights. There is no portability or conversion for AD&D and disability insurance.

Your Right to Continue Coverage – COBRA

If you are a Benefits-Eligible Employee who became eligible for severance benefits and elected to receive the salary-continuation benefit in periodic installments, the Qualifying Event that triggers COBRA eligibility and timelines for you and your covered Dependents will occur at the end of your severance period. If you are a Benefits-Eligible Employee who became eligible for severance benefits and elected to receive the salary continuation benefit in the form of a lump sum, the Qualifying Event for you and your covered Dependents will occur as of your elimination date. You may be eligible for an employer contribution toward the cost of your COBRA coverage.

If You Retire

If 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), in which case you will have the option to continue retiree benefits as applicable. If you are a Benefits-Eligible Employee who became eligible for severance benefits and elected to receive the salary-continuation benefit in periodic installments, your separation date will occur at the end of your severance period. If you are a Benefits-Eligible Employee who became eligible for severance benefits and elected to receive the salary continuation benefit in the form of a lump sum, your separation date is your elimination date. You may be entitled to an employer contribution toward your retiree health insurance premium.