

**THE GEORGE WASHINGTON UNIVERSITY  
HEALTH INSURANCE PLAN  
SUMMARY PLAN DESCRIPTION  
(CIGNA PPO – RETIREES)**

Effective date: January 1, 2005

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## INTRODUCTION

The George Washington University (the “University”) maintains the George Washington University Health Insurance Plan (the “Plan”) to provide health benefits for its eligible employees and retirees. The Plan provides the following health benefit options to participants:

- CareFirst PPO (active participants, Dependents and retirees);
- CIGNA POS (active participants, Dependents and retirees who are under age 65 and living in the service area);
- CIGNA PPO (retirees and Dependents only); and
- CIGNA HMO (active participants, Dependents and retirees who are under age 65 and living in the service area).

This document, together with the booklets and other descriptive materials you have received from the University and the third party administrators, constitutes a summary plan description (“SPD”) for the Plan with respect to the **CIGNA PPO option**, as required by the Employee Retirement Income Security Act of 1974 (“ERISA”). The SPD is intended to describe the benefits that the University has made available to you as a participant in the Plan under the **CIGNA PPO option**. Moreover, this document, together with the contracts and agreements that the University has entered into with the benefit providers under the Plan, constitutes the written plan document. You and your Dependents may examine the documents constituting the Plan, and certain other documents and records pertaining to the Plan, during regular business hours or by appointment at a mutually convenient time at the University’s Benefit Services Division by calling (202) 994-9620. You may obtain copies of the documents constituting the Plan and of certain reports by contacting the University’s Benefit Services Division at (202) 994-9620 (a reasonable charge may be imposed for those copies, as permitted by federal regulation).

Certain capitalized terms used in this SPD have been defined in this document.

Please Note: If there is any conflict or inconsistency between this document and the contracts and agreements that the University entered into with the benefit providers under the Plan with respect to the benefits payable hereunder, the contracts and agreements will control. The Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the University and does not give you the right to be retained in the employment of the University.

## **ELIGIBILITY TO PARTICIPATE**

### ***Retirees Eligible for Coverage***

An eligible retiree is an eligible employee who, at the time of retirement is covered under the Plan (or is eligible for special enrollment rights) and is:

- age 55 to 60 with 20 or more years of service credit with the University;
- age 60 to 65 with 10 or more years of service credit with the University; or
- age 65 or over with any number of years of service credit with the University.

### ***Dependents***

If you are eligible for participation in the Plan, your Dependents are also eligible for coverage. For purposes of this Plan, “Dependent” means your spouse, your Domestic Partner, or a child who meets the following requirements:

- is unmarried and:
  - is your child by birth, your legally adopted child or your grandchild;
  - is a child for whom you are the legally recognized proposed adoptive parent, who is a member of your household and primarily supported by you before an adoption becomes final;
  - is a child of your Domestic Partner who lives with you and who is primarily supported by you;
  - is your stepchild who is a member of your household and who is primarily supported by you;
  - is your child or grandchild for whom a court has granted you custody, provided that the child is a member of your household and is primarily supported by you; or
  - is your grandchild, niece, or nephew (i) to whom you provide food, clothing and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session; (ii) you provide proof, upon application, that the child meets the requirements for coverage as a primary care Dependent, including proof of the child’s relationship and primary dependency on you, and certification that the child’s legal guardian does not have other coverage; and (iii) if the child’s legal guardian is someone other than you, the child’s legal guardian is not covered under an accident or sickness policy.
- An eligible child must be:
  - under age 19;
  - between ages 19 and 26 if attending an accredited school, college, or university on a full-time basis (a minimum of 12 credit hours per semester) and if you provided CIGNA with proof of the child’s student status within 31 days after the child’s 19th birthday, or within 31 days after the effective date of the child’s coverage under the Plan, whichever is later, and annually thereafter; or

- age 19 or over and meet the following requirements:
  - the child is incapable of supporting himself or herself because of mental or physical incapacity;
  - the mental or physical incapacity occurred before the child reached age 19 or, if the child was covered beyond age 19 as a student Dependent, the incapacity occurred while the child was a student Dependent;
  - the incapacitated child is chiefly dependent upon you or your spouse for support and maintenance; and
  - you provide CIGNA with proof in writing of the child's incapacity and dependency on you or your spouse, or your Domestic Partner, including certification by a physician, within 31 days after the child's coverage would otherwise terminate, or within 31 days after the effective date of the child's coverage under the Plan, whichever is later. CIGNA has the right to verify whether the child is, and continues to qualify as, an incapacitated child.

Domestic Partner means a person of the same sex who:

- shares your permanent primary residence;
- has resided with you for no less than six months;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least three of the following arrangements: joint mortgage or lease or other written evidence of common residence, such as joint utility bills; joint checking account; joint credit account; joint ownership of a motor vehicle; designation of domestic partner as primary beneficiary in will; designation of domestic partner as primary beneficiary of life insurance policy or retirement plan funds; durable property or health care power of attorney;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to CIGNA upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within six months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

## **PRE-EXISTING CONDITIONS**

When you initially enroll in the Plan, you and your Dependents will be subject to a 12-month Pre-existing Condition Exclusion Period. During this time, coverage for pre-existing conditions will not be provided under this Plan. The Pre-existing Condition exclusion period will be reduced by the amount of prior Creditable Coverage that you and your Dependents have as of the Enrollment Date, unless there is a Significant Break in Coverage immediately preceding the Enrollment Date. In order to demonstrate that you had Creditable Coverage, you may request a certificate of coverage from your prior plan. You may request assistance from CIGNA or the University's Benefit Services Division to obtain a certificate of coverage from your prior plan.

For purposes of this section the following terms have been defined:

- *Pre-existing Condition.* A condition (whether physical or mental, regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received by a licensed practitioner within a six-month period ending on the Enrollment Date. A Pre-existing Condition will not include pregnancy.
- *Enrollment Date.* The first day of coverage.
- *Creditable Coverage.* Generally means coverage of an individual under another health plan (for example, another employer's plan, and individual plan, Medicare, etc.).
- *Significant Break in Coverage.* The period of 63 consecutive days during all of which the individual does not have any Creditable Coverage.

## **ENROLLMENT ELECTIONS**

### ***Initial Enrollment***

When you first become eligible for retiree coverage, you must enroll within 30 days from the date your coverage as an active employee terminated. The University will send you the applicable election forms for you to enroll in retiree coverage. You must complete the forms accurately and correctly for coverage to take effect and return the completed forms to the University's Benefits Services Division. If you enroll for retiree coverage within this 30-day period, your retiree coverage will be effective when your coverage as an active employee terminates. **If you do not enroll for retiree coverage during the initial 30-day period, you may not enroll at a later time unless you qualify for special enrollment rights (described below).**

***Please Note*** that to enroll in this CIGNA PPO option you do not have to live or work within the CIGNA service area. (The CIGNA service area is the District of Columbia, Maryland and Virginia, based on area zip codes.)

### ***Open Enrollment***

Each fall the University has an open enrollment period during which you may make certain changes to existing benefits. You may elect to change your retiree coverage from CIGNA to CareFirst, or from CareFirst to CIGNA during open enrollment period (you must be living within the CIGNA service area to choose the CIGNA HMO or POS option).

If you make changes to your coverage during open enrollment, your election will become effective as of January 1 of the following year. If you are enrolled in the CIGNA HMO or POS options, and you leave the CIGNA service area, you do not have to wait for open enrollment to change from CIGNA to CareFirst (but must do so within 31 days of moving).

**Please note** that you may not increase retiree coverage at any time unless you qualify for special enrollment rights (described below), or unless you have a new family member who qualifies as an eligible Dependent.

### ***New Dependents***

You may enroll new family members that qualify as Dependents within 31 days following the date the new family member first becomes eligible for coverage. If you do not enroll your new Dependent within this 31-day period and your new Dependent does not qualify for special enrollment rights, you will not be able to add your new Dependent later. If you enroll your new Dependent within the 31-day period, your new Dependent will be covered as of the Dependent's first eligibility date.

### ***Special Enrollment Rights***

If you decline enrollment for yourself or your Dependents (including your spouse or Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in the Plan, provided that you request enrollment within 31 days after your other coverage ends and such other coverage was lost due to (i) the loss of eligibility for such other coverage, (ii) the cessation of employer contributions for such other coverage, or (iii) the exhaustion of COBRA coverage. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your newly added Dependent(s), provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

### ***Changes to Enrollment Choices***

Generally, you may not make changes to your coverage elections during the Plan Year, but you may change your elections during the Plan Year if you have a change in status. Your election change must be consistent with the change in status. Events considered as causing a change in status include:

- marriage, death of spouse or Domestic Partner, divorce, legal separation, annulment, termination of Domestic Partner relationship;
- birth, adoption, death of Dependent;
- change in your or a Dependent's employment status;
- Dependent is no longer eligible for coverage due to age, student status, or similar circumstance;
- change in your or a Dependent's residence;
- significant change in cost of coverage;
- changes as may be required pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that require health coverage for a child;

- COBRA coverage is exhausted;
- custody changes; and
- entitlement to Medicare or Medicaid.

If you wish to change your elections due to a change in status, you must notify the Plan Administrator within 31 days of the change in status event by submitting the appropriate form to the University's Benefit Services Division. Forms can be obtained on-line at the University's HRS website at [www.gwu.edu/hrs/forms](http://www.gwu.edu/hrs/forms) or by contacting the University's Benefit Services Division at (202) 994-9620 Your election will be changed effective as of the first of the month beginning after the date your completed request for the election change is received by CIGNA; provided, however, in the case of the birth, adoption, or placement for adoption of a new Dependent, your change in coverage will be retroactive to the date of such event. Retirees may be restricted from making certain types of changes to their elections.

### **CONTRIBUTIONS**

You may be required to contribute toward the cost of your coverage. When you enroll in retiree coverage, the University will notify its third party payroll provider of your election to participate in the retiree portion of this Plan and the third party payroll provider will send you information regarding how to make your contributions.

### **CESSATION OF PARTICIPATION**

Your participation in the Plan ends on the earliest of:

- the date the Plan is terminated;
- the last day of the calendar month in which you are no longer eligible for the Plan; or
- the last day of the period for which you made any required contributions.

Coverage under the Plan for all of your Dependents will cease on the earliest date below:

- the date your participation ceases;
- the last day of the calendar month in which the Dependent first becomes ineligible; or
- the last day for which you have made any required contribution for your Dependents.

Notwithstanding the above, CIGNA or the Plan Administrator may, in its sole discretion, cause your participation in the Plan to terminate if you provide false information or make misrepresentations in connection with a claim for benefits; permit a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions.

Under certain circumstances, your coverage under the Plan may continue after the date coverage would otherwise end. If you are an inpatient in a hospital or a skilled nursing facility on the date of this Plan is terminated, coverage will continue until the earlier of (i) your discharge from the hospital, (ii) the date when inpatient care is no longer medically required, (iii) the date you are

covered through replacement coverage offered by the University, or (iv) 180 days after the Plan's termination.

You and your Dependents may be eligible for continuation coverage under COBRA after your participation in the Plan ends. Please see the section entitled **CONTINUATION OF COVERAGE UNDER COBRA** for details (page 33).

## **PROVIDERS**

You can choose to receive covered services from either a Participating Provider, or a non-Participating Provider. Your costs (co-payments, coinsurance, deductible, unpaid balance) will depend on which type of provider you choose.

- **In-Network services** – your costs will generally be lower if you choose to receive care from Participating Providers. You will be responsible for paying a specified co-payment (a flat dollar amount), but there is no coinsurance or deductible applied to In-Network services. *Note that there are limits that apply to specified services; see the **SCHEDULE OF BENEFITS** section for details (page 9).*
- **Out-of-Network services** – Plan benefits will be reduced if you choose to receive care from non-Participating Providers. You will be responsible for an annual deductible as well as coinsurance (a percentage of the applicable Plan allowance for a particular service). In addition, you will be responsible for any charges that are over the applicable Plan allowance amount if the non-participating provider bills you for these charges. *Note that there are limits that apply to specified services; see the **SCHEDULE OF BENEFITS** section for details (page 9).*

You can obtain Participating Provider information directly from CIGNA by calling (800) 244-6224, or going on-line to access the CIGNA provider directory at [www.cigna.com](http://www.cigna.com). You may also contact the University's Benefit Services Division at (202) 994-9620.

### ***Related Definitions***

- “In-Network” – In-Network care is provided by a Participating Provider.
- “Out-of-Network” – Out-of-Network care is care provided by a non-Participating Provider.
- “Participating Provider” – Participating Provider means an institution, facility, agency or health care professional that has contracted directly or indirectly with CIGNA to provide care for CIGNA members. The list of Participating Providers may change from time to time. Up to date information for the provider directory can be found at [www.cigna.com](http://www.cigna.com), or by calling CIGNA at (800) 244-6224. You can also contact the University's Benefit Services Division at (202) 994-9620.

### ***Guest Privileges if Residing Temporarily in Another Location***

If you or a covered Dependent will be residing temporarily in another location where there is a network of Participating Providers, you may be eligible for In-Network benefits at that location. However, the benefits available at the host location may differ from those described in this SPD. If you need these benefits, you should contact CIGNA Member Services at (800) 244-6224 for more information.

## **PAYMENT OF COVERED MEDICAL EXPENSES**

### ***Covered Expenses***

“Covered expenses” means expenses incurred for services that are described in this SPD to the extent that they are recommended by a Physician, and are considered medically necessary for the care and treatment of an injury or a sickness, as determined by CIGNA.

### ***Deductible***

- In-Network — There is no deductible applied to covered medical services rendered by Participating Providers.
- Out-of-Network - For most covered Out-of-Network services, the Plan does not begin to pay benefits until the applicable deductible is satisfied for that year. The deductible will be calculated on a calendar year basis. Until the applicable deductible is satisfied, you or your Dependents must pay for covered Out-of-Network services. Once the deductible has been satisfied, the Plan will pay for covered services, less any applicable coinsurance. The individual deductible is \$750 per calendar year and the family deductible is \$1,500 per calendar year. The family deductible can be satisfied by combining eligible expenses for any or all family members.

### ***Co-payment***

Generally, co-payments apply only to In-Network benefits. You will be responsible for applicable co-payments for covered medical services, as described in the **SCHEDULE OF BENEFITS** section (page 9). The Plan will pay your Participating Provider for the covered portion of the medical services rendered, and you will not be responsible for the balance, if any.

### ***Coinsurance (Out-of-Network only)***

Generally, coinsurance only applies to Out-of-Network benefits. For most covered services, the Plan will pay a percentage of an allowed amount once the deductible is met and you will pay a percentage of that allowed amount. Your percentage is referred to as the coinsurance. For most Out-of-Network services, your coinsurance amount is 30% of the applicable Plan allowance.

### ***Out of Pocket Limit (Out-of-Network only)***

Once a covered individual, or family member, has incurred “out-of-pocket” expenses (deductible or coinsurance amounts) for covered services that reach the Out-of-Pocket Limit within a calendar year, CIGNA will pay 100% of covered expenses for the rest of that year. The individual Out-of-Pocket Limit is \$5,000; the family Out-of-Pocket Limit is \$10,000. The family Out-of-Pocket Limit can be satisfied by combining eligible expenses for any and all family members.

## **PRIOR AUTHORIZATION REQUIREMENT**

For certain services, prior authorization is required in order for those services to be covered services under the Plan. “Prior authorization” is the approval that you must receive from CIGNA *before the services described below are rendered.*

Services that require prior authorization include, but are not limited to:

- inpatient hospital services
- inpatient services at any other participating healthcare facility;
- partial hospitalization for treatment of mental health or substance abuse;
- residential treatment services for mental health or substance abuse;

If you are using the services described above, you must obtain “pre-admission certification” (“PAC”) and “continued stay review” (“CSR”) before you are admitted to a hospital (unless you are in an emergency situation) as a registered bed patient or for mental health and substance abuse residential treatment services.

- “Pre-Admission Certification” is used by a review organization (that contracts with CIGNA) to certify the medical necessity of a hospital admission. See the definition of “medically necessary” in the **SCHEDULE OF BENEFITS** section, below.
- “Continued Stay Review” is used by a review organization (that contracts with CIGNA), to certify the appropriate length of a hospital admission.

It is your responsibility to contact the review organization to request PAC and CSR, *before you are admitted*. You or your doctor can contact the review organization by calling Member Services at (800) 244-6224. If you are admitted in an emergency situation, you must contact the review organization within 48 hours from admission. For an anticipated hospital admission due to pregnancy, you should call the review organization by the end of the third month of pregnancy.

If PAC is not properly requested and received for a hospital admission, covered expenses will not include the first \$500 in charges made for that admission. In the event PAC and CSR have been requested and received, but covered services were in excess of those services approved through PAC and CSR, no benefits will be provided in excess of approved benefits.

## **SCHEDULE OF BENEFITS**

The services listed below are covered services to the extent that they are medically necessary for the care and treatment of an injury or illness, as determined by CIGNA. Keep in mind that in certain cases prior authorization is necessary.

### ***Medically Necessary***

“Medically necessary” is defined as services provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under clinical trials, not for experimental, investigational, or cosmetic purposes. In addition, the services must be necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, or disease, or its symptoms.

### ***Primary Care and Preventive Care Services***

Routine examinations, immunizations and well-child care, and medically necessary services are covered after you pay the applicable co-payment if provided by Participating Providers, or after you pay the applicable coinsurance and deductible if provided by non-Participating Providers.

The following services are covered (note that the Out-of-Network coinsurance is based upon the applicable Plan allowance for each covered expense):

- Routine office visits and lab work — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Routine physicals (including vision and hearing through age 16) — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Routine gynecological visits — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Immunizations — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Pap test — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Routine mammogram for women who are age 35 to 69 — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Prostate screening — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Office visit with a diagnosis — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Surgical procedures — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Allergy injections — \$20 co-payment or the actual charge, if less for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.

### ***Specialty and Outpatient Care Services***

The Plan covers specialty and outpatient services, but note that you generally must have prior authorization (and an approved referral from your PCP, if necessary) for these services to be covered as In-Network benefits.

- Office visits with a specialist — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Outpatient facility services (operating room, recovery room, procedures room and treatment) — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Surgical and nonsurgical care for temporomandibular joint dysfunction (TMJ), excluding appliances and orthodontic treatment — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Laboratory and radiology services — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Magnetic resonance imaging, magnetic resonance angiography, computerized axial tomography, and positron emission tomography — \$25 co-payment per procedure for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.

- Anesthetics and their administration — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Radium and radioactive isotope treatment, chemotherapy, blood transfusions, oxygen and other gases and their administration, therapy provided by an approved licensed physical, occupational or speech therapist — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Infertility treatment.
  - Infertility services include coverage for approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy and are covered as follows:
    - office visit — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
    - surgery — \$200 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
    - inpatient care — \$150 per day co-payment, limited to \$750 in the aggregate, for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
    - outpatient care — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
    - physician's services — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
  - The following items are specifically excluded from coverage of infertility treatment:
    - infertility drugs;
    - gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and variations of these procedures;
    - any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees);
    - a reversal of voluntary sterilization;
    - infertility services when the infertility is caused by or related to voluntary sterilization;
    - cryopreservation of donor sperm and eggs; and
    - any experimental or investigational infertility procedures or therapies.
- Maternity care services:
  - initial office visit to confirm pregnancy — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.

- all subsequent pre-natal and post-natal visits — no charge payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- delivery (including care provided at approved birthing centers) — \$150 per day co-payment, limited to \$750 in the aggregate, for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care. As required by Federal law, the mother has the option to remain in the hospital after delivery for up to 48 hours for a vaginal delivery, or up to 96 hours for a cesarean delivery.
- Elective or non-elective abortion (inpatient, if medically necessary, or outpatient) — \$150 per day co-payment, limited to \$750 in the aggregate, for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Family Planning:
  - office visit — \$20 co-payment
  - surgical sterilization (vasectomy or tubal ligation)
    - Inpatient — \$150 per day co-payment, limited to \$750 in the aggregate, for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
    - Outpatient — no charge payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Short-term rehabilitation services (outpatient) and chiropractic services — \$20 co-payment for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care. Coverage for short-term rehabilitation and chiropractic visits are limited to 60 visits per year.
  - Short-term rehabilitation therapy is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.
  - Chiropractic services are covered when provided in an outpatient setting, and include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.
  - The following limitations apply:
    - Occupational therapy is provided only for purposes of training members to perform the activities of daily living.
    - Speech therapy is not covered when (i) used to improve speech skills that have not fully developed; (ii) considered custodial or educational; (iii) intended to maintain speech communication; or (iv) not restorative in nature.
    - Multiple services provided on the same day constitute one visit, but a separate co-payment will apply to the services provided by each Physician.

- Durable medical equipment — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
  - “Durable medical equipment” consists of items designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of injury or sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches, hospital beds, wheel chairs, respirators, and dialysis machines. Coverage is not provided for repair or replacement except when necessary due to growth or a change in medical condition.
  - Unless otherwise specifically provided for in this SPD, the following items are excluded from coverage:
    - Hygienic or self-help items or equipment;
    - Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
    - Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
    - Institutional equipment, such as air fluidized beds and diathermy machines;
    - Elastic stockings and wigs;
    - Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
    - Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
    - Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.
- External prosthesis initial purchase and fitting, used as replacements for missing body parts, to include only artificial arms and legs and terminal devices such as hands or hooks; replacement of such prosthesis is covered only if needed due to normal anatomical growth — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.

### ***Home Health Care***

There is no charge for home health care that has prior authorization and is approved by CIGNA for In-Network care, and there is 30% coinsurance after the deductible is met for Out-of-Network care. Visits are limited to 40 visits per year for Out-of-Network, reduced by the number of In-Network visits received.

“Home health care services” are skilled health care services that can be provided during intermittent visits of two hours or less by “other health care professionals.”

“Other health care professionals” include individuals, other than physicians, who are licensed or otherwise authorized under the applicable state laws to deliver medical services and supplies.

“Other health care professionals” includes, but is not limited to, physical therapists, registered nurses, and licensed practical nurses.

- Conditions for coverage. Home health care services are provided under the Plan only if CIGNA determines that the home is a medically appropriate and cost-effective setting, and the following conditions are met:
  - you require skilled care;
  - you are unable to obtain the required care as an ambulatory outpatient; and
  - you do not require confinement in a hospital or other health care facility.
- Medically necessary care and supplies are covered when administered or used by other health care professionals, such as:
  - consumable medical supplies
  - home infusion therapy
  - durable medical equipment
- Home health care services do not include services of a person who is a member of your family or your Dependent’s family, or who normally resides in your house or your Dependent’s house.
- If care is provided for a minor or an adult who is dependent upon others for nonskilled care (*e.g.* bathing, eating, toileting), home health care services will only be provided during times when there is no family member or care giver present in the home to meet the individual’s nonskilled care needs. As a general matter, coverage is not available for home health care services that are custodial in nature (*i.e.*, assistance with day-to-day living such as bathing, eating, and toileting).

### ***Inpatient Care Services***

If you are hospitalized by a Participating Provider and you obtain prior authorization (other than in cases of emergencies) the services listed below will be covered.

- Inpatient physician’s visit — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Hospital inpatient healthcare facilities —\$150 per day co-payment, limited to \$750 in the aggregate, for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
- Inpatient care in skilled nursing facilities, rehabilitation facilities, or subacute facilities — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care. Coverage is limited to 60 days per year.
- Organ transplant services — \$150 per day co-payment, limited to \$750 in the aggregate, for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
  - Coverage is provided for charges made for human-to-human organ and tissue transplant services at facilities throughout the United States, as designated by CIGNA. Covered transplants include:

- allogeneic bone marrow/stem cell,
  - autologous bone marrow/stem cell,
  - cornea,
  - heart,
  - heart/lung,
  - lung
  - kidney,
  - kidney/pancreas,
  - pancreas
  - liver, or
  - small bowel/liver.
- Coverage includes the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement (procurement costs include surgery for removal of organ, organ transportation and/or transportation, hospitalization and surgery of a live donor).
  - Organ transplant travel benefits for the recipient of a transplant, and for a companion (spouse, family member, legal guardian, non-relative actively involved as your caregiver) will be covered for travel that has prior authorization and approval from CIGNA, to an approved facility. Travel benefits are limited to a lifetime maximum of \$10,000. There is no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.
    - Covered travel expenses include charges for transportation, lodging and food associated with the transplant.
    - Travel benefits are not available for cornea, kidney and autologous bone marrow/stem cell transplants.
    - Travel benefits do not cover personal expenses, such as, but not limited to: travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and transportation charges that exceed coach class rates.

### ***Hospice Care Services***

If you are referred to a hospice care facility by a Participating Provider, with prior authorization, the services below will be covered as In-Network. For care provided at an inpatient care/facility or outpatient care facility, you are responsible for 20% of covered charges;; for Out-of-Network care, you are responsible for 30% coinsurance after the deductible is met. There is a lifetime maximum benefit of 180 days for hospice services.

The following hospice care services are covered for an individual who has been diagnosed as having six months or fewer to live, due to terminal illness:

- services incurred at a hospice facility for bed and board and services and supplies;
- services incurred at a hospice facility for services provided on an outpatient basis;

- services provided by a physician for professional services;
- services provided by a psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- services provided for pain relief treatment, including drugs, medicines and medical supplies; and
- charges by an “other health care facility” for:
  - part-time or intermittent nursing care by or under the supervision of a nurse;
  - part-time or intermittent services of an “other health care professional”;
  - physical, occupational and speech therapy;
  - medical supplies; drugs and medicine lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent such charges would have been payable under the Plan if the person had remained or been confined in a hospital or hospice facility.

“*Other health care facility*” means a facility other than a hospital or a hospice facility, including but not limited to licensed skilled nursing facilities, rehabilitation hospitals, and subacute facilities.

The following charges for hospice care services are not covered:

- services provided by a person who is a member of your family or your Dependent’s family or who normally resides in your house or your Dependent’s house;
- services provided during any period when you or your Dependent is not under the care of a physician;
- services or supplies that are not listed under *Hospice Care Services*;
- services for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the Plan; and
- services or supplies that are primarily to aid you or your Dependent in daily living.

### ***Cosmetic Services***

Coverage will be provided for reconstructive cosmetic surgery only if, in CIGNA’s judgment, the surgery is:

- medically necessary to correct conditions that resulted in a functional physiological defect; or
- required to correct conditions that resulted from accidental injury or non-cosmetic surgery if:
  - the accident or surgery has produced a major physical effect on your appearance, and
  - in CIGNA’s judgment, the surgery can be expected to correct the condition; or

- required to correct a congenital anomaly that has produced a major physical effect on your condition, provided the surgery or procedure can reasonably be expected to correct the condition.

### ***Reconstructive Breast Surgery***

Coverage will be provided for reconstructive breast surgery resulting from a mastectomy — no charge for In-Network care; 30% coinsurance after the deductible is met for Out-of-Network care.

- “Mastectomy” means the surgical removal of all or a part of a breast as a result of breast cancer.
- “Reconstructive breast surgery” means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes the augmentation mammoplasty, reduction mammoplasty and mastopexy. Covered Reconstructive breast surgery includes (i) all stages of Reconstructive breast surgery performed on a diseased breast and surgery performed on a non-diseased breast to establish symmetry with the diseased breast after Reconstructive breast surgery on the diseased breast is performed; (ii) prostheses and (iii) treatment of physical complications of the Mastectomy, including lymphedemas.

### ***Emergency Care/Urgent Care Services***

The Plan covers authorized emergency care and urgent care services after you pay the applicable co-payment as shown below.

- Physician’s office — \$20 co-payment for In-Network care and Out-of-Network care.
- Emergency room — \$75 co-payment, which is waived if you are admitted to the hospital directly from the emergency room for In-Network care and Out-of-Network care.
- Urgent care/outpatient facility — \$75 co-payment, which is waived if you are admitted to the hospital directly from the facility for In-Network care and Out-of-Network care.
- Ambulance service — no charge for In-Network care and Out-of-Network care (30% coinsurance if service is non-emergency).

### ***Mental Health and Substance Abuse Services***

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

- Inpatient mental health services — Coverage is limited to 45 days per calendar year. \$100 per day co-payment for In-Network care; 50% coinsurance after the deductible is met for Out-of-Network care. ***Services must be preauthorized and approved by CIGNA while you are confined for the evaluation and treatment of mental health; CIGNA must provide PAC and CSR prior to admission.***
  - Inpatient mental health services are services provided by a hospital or a mental health residential treatment center.

- “Partial hospitalization.” A partial hospitalization can occur when benefits are provided for not less than four hours and not more than 12 hours in any 24 hour period. You may count two partial hospitalizations as one inpatient day (when counting toward the coverage limitation of 45 days for inpatient mental health services).
- Two days of care while confined in a “mental health residential treatment” center only counts as one day of inpatient mental health treatment (*e.g.*, if you are confined in a mental health residential treatment center for four days, it counts as two days toward your inpatient care limit of 45 days).
- “Mental health residential treatment center.” A mental health residential treatment center is an institution which (i) specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; (ii) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of physicians; (iii) provides 24-hour care, in which a person lives in an open setting; and (iv) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
- Outpatient mental health services — For In-Network care the first 40 visits in a calendar year have a co-payment of \$20 per visit; for visits after the first 40 visits in the same calendar year, the co-payment is \$40 per visit; group therapy visits have a \$10 co-payment. For Out-of-Network care, outpatient mental health services are reimbursed require 50% coinsurance after the deductible is met.
  - Outpatient mental health services are services of providers who are qualified to treat mental health when treatment is provided on an outpatient basis (while you are not confined in a hospital or mental health residential treatment center), in an individual or group therapy program.
  - Covered services include, but are not limited to, treatment for:
    - anxiety or depression which interferes with daily functioning;
    - emotional adjustment or concerns related to chronic conditions, such as psychosis or depression;
    - emotional reactions associated with marital problems or divorce;
    - child/adolescent problems of conduct or poor impulse control;
    - affective disorders;
    - suicidal or homicidal threats or acts;
    - eating disorders;
    - acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention); and
    - outpatient testing and assessment.

Substance abuse services are services that are required to diagnose and treat psychological or physical dependence on alcohol or other mind-altering drugs. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be

charges made for treatment of substance abuse. ***Services must be preauthorized and approved by CIGNA while you are confined for the evaluation and treatment of substance abuse: CIGNA must provide PAC and CSR prior to admission.***

- Inpatient substance abuse services — Coverage is limited to 30 days per calendar year. \$50 per day co-payment for In-Network care; 50% coinsurance after the deductible for Out-of-Network care.
  - Inpatient substance abuse services are services provided by a hospital or a substance abuse residential treatment center, approved by CIGNA, while you are confined for the evaluation and treatment of substance abuse.
  - “Partial hospitalization.” A partial hospitalization can occur when benefits are provided for not less than four hours and not more than 12 hours in any 24 hour period. You may count two partial hospitalizations as one inpatient day (when counting toward the coverage limitation of 30 days for inpatient substance abuse services).
  - Two days of care while confined in a “substance abuse treatment” center only counts as one day of inpatient substance abuse treatment (*e.g.*, if you are confined in a substance abuse treatment center for four days, it counts as two days toward your inpatient care limit of 30 days).
  - “Substance abuse treatment center” means an institution which: (i) specializes in the treatment of psychological and social disturbances that are the result of substance abuse conditions; (ii) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of physicians; (iii) provides 24-hour care, in which a person lives in an open setting; and (iv) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
- Outpatient substance abuse services — For In-Network care the first 40 visits in a calendar year have a co-payment of \$20 per visit; for visits after the first 40 visits in the same calendar year, the co-payment is \$40 per visit; group therapy visits have a \$10 co-payment. For Out-of-Network care, outpatient mental health services are subject to a 50% coinsurance after the deductible is met and is limited to 30 visits per calendar year *except that two group therapy visits only count as one visit toward the 30 visit limit.*
- Substance abuse detoxification services (detoxification and related medical ancillary care) may be provided on an inpatient or an outpatient basis. Approval from CIGNA will be based on medical necessity for each situation.

Mental Health and Substance Abuse Coverage Exclusions. The following services are specifically excluded from mental health and substance abuse coverage:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under the Plan.
- Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

### ***Vision Care Services***

In-Network, routine vision care services are covered for one exam every 24 months — \$10 co-payment. In addition, discounted services for glasses and contact lenses are available from participating vendors. You must use a participating vision care provider in order for the services to be covered. For a list of participating providers and vendors, you can visit [www.cigna.com](http://www.cigna.com) or call (800) 244-6224. You may also contact the University's Benefit Services Division at (202) 994-9620.

## **COVERAGE EXCLUSIONS**

Coverage will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery or therapy unless coverage is provided under the section entitled **SCHEDULE OF BENEFITS** (page 9).
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that coverage will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (i) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (ii) charges made by a hospital for bed and board or necessary services and supplies; or (iii) charges made by a free-standing surgical facility or the outpatient department of a hospital in connection with surgery.
- for which benefits are not payable according to the section entitled **GENERAL LIMITATIONS** (page 21); except that: (i) the limitations with respect to a maximum for multiple surgical procedures or an allowable charge for an assistant surgeon or cosurgeon; and (ii) the limitation with respect to routine eye refractions will not apply to coverage for complete eye examinations.

- for or in connection with procedures to reverse sterilization.
- for all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided under the section entitled **SCHEDULE OF BENEFITS** (page 9).
- for replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- for medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
- unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- for therapy to improve general physical condition if not medically necessary, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
- treatment by acupuncture.
- consumable medical supplies, including but not limited to: bandages and other disposable medical supplies, skin preparations except as provided under the section entitled **SCHEDULE OF BENEFITS** (page 9).
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, dentures and wigs.

### **GENERAL LIMITATIONS**

No coverage will be provided for expenses incurred by you or your Dependents:

- for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected sickness or injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;

- for charges which would not have been made if the person had no insurance;
- for charges that are not medically necessary, except as specified in any certification requirement shown in the **SCHEDULE OF BENEFITS** (page 9);
- for or in connection with custodial services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- to the extent of the exclusions imposed by any certification requirement shown in the **SCHEDULE OF BENEFITS** (page 9) apply.
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.
- for charges made for or in conjunction with the purchase of replacement contact lenses except as specifically provided under the **SCHEDULE OF BENEFITS** (page 9); however, the purchase of the first pair of contact lenses that follow cataract surgery will be covered.
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered medically necessary for the care and treatment of an injury or sickness, as determined by CIGNA;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (i) used to improve speech skills that have not fully developed; (ii) can be considered custodial or educational; or (iii) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.
- for any services (including experimental, investigational or unproven) that are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by CIGNA, to be:
  - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or
  - the subject of review or approval by an Institutional Review Board for the proposed use; or

- the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
- not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- for expenses incurred by you to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
  - a “no-fault” insurance law; or
  - an uninsured motorist insurance law.

## **CAREMARK PRESCRIPTION DRUG PROGRAM**

Caremark Rx, Inc. administers the prescription drug benefit and has an extensive network of participating pharmacies, and a mail order program, which offer discounted prices for your eligible prescription drugs. ***Note that you will receive a prescription card that is separate from your medical coverage I.D. card - - you will not be able to use your medical coverage I.D. card to obtain prescription benefits.*** Your prescription must be for a drug that is on the Caremark preferred drug list to be reimbursable under this program. A copy of the preferred drug list is provided to you upon enrollment. You may also determine whether a particular drug is covered by using the pricing tool at [www.caremark.com](http://www.caremark.com).

### ***Prescription Drug Program Deductible***

The prescription drug program does not begin to pay benefits until a \$100 deductible is satisfied for that year. The deductible will be calculated on a calendar year basis, and will apply to you and each covered Dependent for each year. Until the applicable deductible is satisfied, you or your Dependents must pay for pharmacy services. Once the deductible has been satisfied, the prescription drug program will pay for covered services, less the applicable co-payments (or other charges that may be your responsibility) as shown below.

### ***Pharmacy Benefit***

You can receive up to a 30-day supply of prescription drug benefits if you fill your prescription at a pharmacy.

- **Network Pharmacy.** If you use a network pharmacy your cost will be the co-payment levels listed below after you meet an annual \$100 deductible (this requirement also applies to each covered Dependent each calendar year). Most major pharmacies participate in the Caremark network. To find out if your pharmacy is part of the network, you can review the materials you received with your prescription card, call Caremark at (800) 966-5772, go on-line at [www.caremark.com](http://www.caremark.com), or you can ask your pharmacy.
  - Generic drug co-payment - \$5.00
  - Preferred brand co-payment - \$15.00
  - Non-preferred brand co-payment - \$25.00

- **Out-of-Network Pharmacy.** If you use an out-of-network pharmacy, you will have to pay the full cost of your prescription, and then request reimbursement from Caremark by filing a claim. Each year your reimbursement will be based on the allowable cost for the prescription, less the appropriate co-payment amount after you meet an annual \$100 deductible (this requirement also applies to each covered Dependent each calendar year). You will not be reimbursed for any cost that is over the allowable cost. For example: you fill a prescription for a generic drug at an out-of-network pharmacy and the cost to you is \$25.00. However, the allowable cost for that prescription under this prescription drug program may be only \$20.00 - - your reimbursement from Caremark when you file your claim will be \$15.00 (which is the allowable cost of \$20.00 minus your \$5.00 co-payment). You incur the expense for the co-payment plus the \$5 difference between the allowable cost and the actual cost, so your total expense for the purchase of this prescription at an out-of-network pharmacy would be \$10.00 (instead of just the \$5.00 co-payment that you would pay at a participating pharmacy).

### ***Mail Order Benefit***

If you use the Caremark mail order benefit, you can realize extra savings on maintenance medications by ordering up to a 90 day supply at the co-payment levels listed below. Your medication will be shipped directly to your home, usually within 10 to 14 days. Note that because you will not receive your medications immediately via mail order (as you do when you go to directly to a pharmacy), you should plan ahead and re-order your new supply of maintenance medication before the old supply runs out. To request forms for the prescription mail order benefit, you can call Caremark at (800) 966-5772, or go on-line at [www.caremark.com](http://www.caremark.com). You may also contact the University's Benefit Services Division at (202) 994-9620.

- Generic drug co-payment - \$10.00
- Preferred brand co-payment - \$30.00
- Non-preferred brand co-payment - \$50.00

### ***Preferred Drug List***

The preferred drug list is a list of brand-name and generic prescription drugs that Caremark can obtain for a lower cost than similar brand-name drugs. These drugs are chosen because of their safety, efficacy and cost savings. Coverage under the prescription benefit program is limited to drugs that are listed on the preferred drug list. If your prescription is for a drug that is not listed on the preferred drug list, you will be responsible for the full cost of that drug regardless of where you purchase the drug. If you would like a copy of the current preferred drug list, you can call Caremark at (800) 966-5772 or go on-line at [www.caremark.com](http://www.caremark.com). You may also contact the University's Benefit Services Division at (202) 994-9620.

### ***Prior Authorization***

Certain drugs require prior authorization from Caremark. Your physician should call Caremark at (888) 413-2723 to receive authorization for drugs on the list that follows. If prior authorization is not received, these drugs will not be covered.

- Growth hormones.

- Ceradase and Cerezyme.
- Interferons (*e.g.* Intron-A, Peg-Intron, Copegus, Rebetol).
- Botulinum Toxin (*e.g.* Botox, Myobloc).
- Raptiva (for psoriasis).
- Xolair (for asthma).

### ***Prescription Drug Program Exclusions***

There will be no prescription drug benefits provided for the following drugs.

- Any drug that is not a prescription drug as defined in this SPD, including but not limited to, any drug that legally can be obtained by law without a prescription order, even if requested by a prescription order.
- Therapeutic devices or appliances or other non-medical substances, regardless of their intended use.
- Administration or injection of any drug, including insulin.
- Contraceptive jellies, creams, foams, or devices.
- Drugs used to treat obesity, assist weight reduction, or anorexians.
- Immunization agents, biological sera, blood, or blood plasma. (Note: this is covered under medical.)
- Diabetic testing or monitoring devices. (Note: This is covered under medical.)
- Any drug dispensed for cosmetic purposes.
- Rogaine or other hair stimulants.
- Retin-A for patients over age 30.
- Fluoride Supplements.
- Hematinics (*e.g.* iron supplements).
- Impotence medications other than oral dosage forms.
- Infertility medications.
- Minerals and Nutrient Supplements.
- Smoking deterrents or any smoking cessation aids (all dosage forms).
- Any quantity of drugs dispensed that exceeds the allowed supply and refill amounts.
- Any prescription refilled in excess of the number of refills specified in the prescription order; or any prescription or refill dispensed more than one year after the date of the original prescription order.
- Lost or replaced prescriptions.
- Vaccination Overrides – one per person per year.

- Any drug that is dispensed to, administered to, or consumed by you or your Dependent in whole or in part, while a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home, or any other institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any drug that is consumed or administered at the place where it is dispensed, or any drug that is dispensed by a prescriber. In these cases, the terms governing your medical coverage will apply instead of the terms of this Prescription Drug Program.
- Prescription orders filled prior to the effective date or after the termination date of the coverage provided under this Plan.
- Drugs labeled “Caution -- Limited by Federal law to investigational use”; drugs that are experimental or investigational in nature, or that are dispensed in connection with experimental or investigative services or supplies, including drugs not dispensed in accordance with generally accepted standards of medical practice, and drugs requiring federal or other governmental agency approval not granted at the time they are prescribed.
- Injectable drugs except for insulin, Heparin, Glucagon, Imitrex (limit to 8 pre-filled syringes per month), EpiPen and AnaKit, or those covered under prior authorization.
- RU-486

### **CLAIMS AND APPEAL PROCEDURES**

When you visit a Participating Provider you will not have to file a claim - - all you have to do is present your CIGNA I.D. card. You will be responsible only for the applicable co-payment, if any. If you receive covered services from a non-participating provider, and you pay for those services, you must submit a claim to CIGNA for reimbursement. You can obtain claim forms from CIGNA by going on-line to [www.cigna.com](http://www.cigna.com). Or, you can go on-line at the University’s HRS website at [www.gwu.edu/hrs/forms](http://www.gwu.edu/hrs/forms). Completed claim forms, and appropriate documentation, should be submitted directly to:

CIGNA Healthcare  
 PO Box 5200  
 Scranton, PA 18505-5200

### ***Claim Denials***

If your claim or request for benefits is denied in whole or in part, you will receive written notification from CIGNA within a reasonable period of time, but not later than the following:

<u>Type of claim</u>	<u>Time limit for denial</u>	<u>Time limit extension allowed</u>
Urgent (medically determined)	72 hours	None
Pre-Service	15 days	15 days
Post-Service	30 days	15 days
Concurrent	Prior to termination of care, if sufficient notice	None

The notice of denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If information needed to process your claim is missing, you will be notified (i) within 24 hours of CIGNA's receipt of your claim if it is for an urgent claim, (ii) within five days of CIGNA's receipt of your claim if it is for a pre-service claim, and (iii) within 30 days of CIGNA's receipt of your claim if it is for a post-service claim.

### ***Appeal Procedure***

If a claim is denied, in whole or in part, you have the right to appeal the denial. Your appeal(s) will be reviewed by someone who was not involved in the initial denial decision of your claim. Appeals involving clinical issues will be considered by an appropriate health care professional.

- Level One Appeal – mandatory. If you appeal the claim denial, **you must submit a written appeal to the CIGNA claim office address that is on your I.D. card within 180 days from the initial claim denial.** You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination.

Determination of your Level One Appeal will be made in accordance with the following time limits:

<u>Type of claim</u>	<u>Time limit for appeal response</u>	<u>Time limit extension allowed</u>
Urgent (medically determined)	72 hours	None
Pre-Service	15 days	None
Post-Service	30 days	None
Concurrent	Prior to termination of care, if sufficient notice	None

- Level Two Appeal – mandatory. If you are dissatisfied with the Level One Appeal decision, you may file a Level Two Appeal. **You must submit a written appeal to the CIGNA claim office address that is on your I.D. card within 30 days from the Level One Appeal denial.** You may submit additional written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination.

Determination of your Level Two Appeal will be made in accordance with the following time limits:

<u>Type of claim</u>	<u>Time limit for appeal response</u>	<u>Time limit extension allowed</u>
Urgent (medically determined)	expedited	Not applicable
Pre-Service	15 days	None
Post-Service	30 days	None
Concurrent	Prior to termination of care, if sufficient notice	None

- Level Three Appeal – voluntary. If you are unsatisfied with the outcome of your Level Two Appeal, you may make a request for a voluntary Level Three Appeal review by CIGNA. The request must be in writing, **submitted within 30 days to the CIGNA claim office address that is on your I.D. card.** This appeal will be reviewed by an independent review organization, by individuals who are not employed by CIGNA, and CIGNA will abide by their decision when rendered. In order to be able to request this appeal, the reason for the denial of your Level Two Appeal must be based on a medical necessity or clinical appropriateness determination by CIGNA. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for a Level Three Appeal.

### ***Legal Actions***

Any lawsuit by you or your Dependent against CIGNA, the Plan, or the Plan Administrator must be commenced within two years from the date you or your Dependent received the service for which, or on account of which, payment is being sought. In addition, before you or your Dependent may bring a lawsuit, you or your Dependent must first exhaust the Plan’s mandatory appeals procedures as described above.

## **COORDINATION OF BENEFITS**

This provision applies if you or your Dependents are covered both under this Plan and by another health plan. The term “health plan” means this Plan and: (i) any other health maintenance organization contract or policy, or (ii) any other health insurance contract or policy, regardless of whether issued on an individual or group basis, including a self-insured employer or union health plan or program that pays for health care services. The term “health plan” also includes a health insurance program sponsored by a state, municipal, or other governmental entity. “Health plan” does not include any individual policy or contract for specified diseases or intensive care policy.

When you or your Dependents are covered by two or more health plans and you receive a service that is covered by this Plan and by another health plan, the benefits under this Plan will be coordinated with the other health plan. This prevents overpayment or duplicate payments for the same service. Under the rules to determine payment described below, the “allowable expense” for a covered service is determined first. Then a determination is made as to which plan will be known as the “primary plan” and which will be known as the “secondary plan.” The portion of the allowable expense that each plan pays or assumes is a function of whether the plan is primary or secondary.

### ***Effect on Benefits***

“Allowable expenses” means any portion of an expense that is covered under at least one of your health plans. When a health plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be counted as an allowable expense.

The Plan will coordinate benefits with the other health plan if the benefits under this Plan, when added to the benefits of the other health plan, are greater than the allowable expenses.

If this Plan is primary, CIGNA will ignore the benefits provided by the secondary health plan when determining benefits under this Plan.

If this Plan is secondary, CIGNA will reduce the allowable expenses that this Plan will cover by the amount of total allowable expenses that it is the responsibility of the primary health plan to cover. In no event will the total benefits provided by this Plan exceed the total benefits that it would have provided if it were primary.

### ***Rules to Determine Payment***

To determine which health plan is the primary health plan, the following rules will be followed:

- If the other health plan does not have a Coordination of Benefits provision, it will always be primary.
- If you or your Dependents are enrolled under one health plan as an employee, and under the other health plan as a dependent of an employee, the health plan that covers you or your Dependents in the capacity as an employee is primary.
- If any of your Dependents are enrolled as a dependent under two different health plans - under one as a dependent of one parent and under the other as a dependent of the other parent – the primary health plan will be one of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year. (If both parents have the same date of birth, the health plan that has covered a parent for the longer period of time will be primary.) This rule does not, however, apply if the other health plan follows a different rule to determine the primary health plan. When this occurs, the health plan that has covered a parent for the longer period of time will be primary. In addition, there are special rules for a child of separated or divorced parents, as noted directly below.
- If a court decree imposes financial responsibility for the health care expenses of the child on one of the parents, then the health plan of that parent is primary. If there is no decree, the following rules apply:
  - If the child is covered under one health plan through the parent with custody and under the other health plan through the parent without custody, the health plan of the parent with custody is primary.
  - If the parent with custody has remarried and the child is covered under three health plans: (i) the health plan of the parent without custody, (ii) the health plan of the parent with custody, and (iii) the health plan of the spouse (stepparent) of the parent with custody, the order of payment will be as follows: (A) the health plan of the parent with custody, (B) the health plan of the stepparent, and (C) the health plan of the parent without custody.
  - If none of the above applies, the health plan that has covered you or your Dependents for the longest period of time will be primary. The start of a new health plan does not include:
    - A change in the amount or scope of a health plan's benefits;
    - A change in the entity paying, providing, or administering health plan benefits; or
    - A change from one type of health plan to another (e.g., single employer to multiple or multi-employer plan).

- Where two or more secondary health plans remain, these rules to determine payment will be repeated until liability has been determined with respect to each remaining health plan.

The above rules apply whether or not you or your Dependents actually make a claim for benefits under all the health plans under which you or your Dependents are covered.

### ***Right to Receive and Release Information***

To implement the Coordination of Benefits rules, CIGNA may request written consent and authorization to release medical records and related information. Upon receipt of such consent and authorization, CIGNA will have the right to release or obtain information necessary to process and coordinate claims. By enrolling in the Plan, you agree to furnish CIGNA with any reasonable information that CIGNA seeks to allow it to process claims and coordinate benefits. If you do not furnish such information, CIGNA has the right to deny payments for the claim.

### ***Recovery of Overpayment***

If the Plan mistakenly provides coverage in amounts greater than required by the rules set forth in this SPD, CIGNA or the Plan Administrator will have the right to recover the overpayment from you or from any other person, insurance company, or any other organization that may have gained from the overpayment. You are required to do whatever is necessary to help CIGNA recover excess payments, including the completion and filing of claim forms with other organizations or insurance companies, or refunding to CIGNA or the Plan Administrator the amount of the mistaken payment.

### ***Multiple Coverage Through CIGNA***

If you are covered under this Plan and another group or individual health services contract that is issued by CIGNA or an affiliated entity, you will not be entitled to duplicate benefits or payments. If duplicate coverage occurs, CIGNA will provide benefits according to this provision up to the allowable expenses.

### ***Medicare Eligibility***

When benefits for covered services are paid by Medicare as primary, the Plan will not duplicate those payments. When CIGNA coordinates benefits with Medicare, payments will be based on the Medicare allowance (if the provider accepts Medicare assignment) or the “Medicare Maximum Limiting Charge” (if the provider does not accept assignment from Medicare).

## **THIRD PARTY LIABILITY**

If you or your Dependent receives benefits from the Plan for bodily injuries or illnesses sustained from the acts or omissions of any third party, the Plan shall have the right to be reimbursed in the event you or your Dependent recovers all or any portion of the benefits paid by the Plan by legal action, settlement, or otherwise, regardless of whether such benefits were paid by the Plan prior to or after the date of any such recovery, regardless of legal fees, costs, or expenses incurred by you or your Dependent. You or your Dependent will not be entitled to receive any benefits for such expenses under the Plan unless you or your Dependent signs the Plan’s Subrogation Agreement and agrees to the following conditions:

- To hold in constructive trust any money recovered on your or your Dependent's behalf from a third party, whether by action of law, settlement, or otherwise, who is or may be liable for the injury or illness that gave rise to the claim for benefits from the Plan, including an insurance company or a workers' compensation carrier. This money held in constructive trust shall be promptly repaid to the Plan for the benefits extended by the Plan, up to the amount of recovery. You, your Dependent, or your or your Dependent's attorney (if the attorney is holding the monetary recovery), shall be fiduciaries with respect to the monies held in constructive trust.
- That the Plan has an equitable lien upon any recovery received by you, your Dependent, or your or your Dependent's attorney as a result of compromise or by way of judgment on the claims. The Plan's equitable lien is for the repayment of benefits paid out by the Plan to you or your Dependent or on your or your Dependent's behalf.
- To irrevocably assign to the Plan all rights to recover monetary compensation from a third party, including the right to bring suit in your or your Dependent's name, or to intervene in any action brought by you or your Dependent to the extent of all benefits paid by the Plan and to give notice of this assignment directly to such third parties, their agents, or insurance carriers, or to any agent or attorney who may represent you or your Dependent. The assignment shall entitle the Plan to reimbursement from any sums held or received by the following third parties which are due to you or your Dependent prior to any distribution of benefits to you or your Dependent, and shall provide that such parties shall hold such sums in trust as a fiduciary for the benefit of the Plan. The parties who shall be bound by such assignment are:
  - any party or its insurance carriers making payments to or on behalf of you or your Dependent; or
  - any agent or attorney receiving payments for or on behalf of you or your Dependent.
- To notify the Plan of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries or illnesses, as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of you or your Dependent or the estate of you or your Dependent, or any person claiming a right through you or your Dependent, on a form to be supplied by the Plan.
- To cooperate fully with the Plan Administrator in the exercise of any assignment or right of subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Plan.
- To acknowledge that the Plan shall have the right of recovery by withholding future benefits should you or your Dependent fail to execute an assignment, subrogation agreement or any other documents required herein, or breach any of the terms of this section.
- If there is any reasonable cause to believe that the injuries or illnesses sustained by you or your Dependent were in any way the result of the acts or omissions of one or more third parties, but you or your Dependent disclaims any third party involvements, the Plan shall

have the right to require you or your Dependent to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

### ***Employer or Governmental Benefits***

The Plan will not cover the cost of services nor will it pay for services for any illness, injury, or condition that would otherwise be covered if you will receive coverage from one of the following:

- any federal, state, county, or municipal workers' compensation or employer's liability law or other similar program; or
- any federal, state, county, or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, but excluding Medicare benefits and Medicaid benefits.

### **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**

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

### **CONTINUATION OF COVERAGE UNDER COBRA**

Health care coverage is protection we often take for granted, but sometimes circumstances arise that leave us unprotected. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that has several provisions designed to protect you and your family against a sudden loss of health care coverage if you have a "qualifying event" (explained below) that would cause the loss of your health care coverage provided by the University. The following information outlines the continuation of coverage available under COBRA.

#### ***Explanation of COBRA Continuation Coverage***

COBRA requires most employers that sponsor group health care plans to provide a temporary extension of health care coverage to employees and their Dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called "continuation coverage".

Individuals who are eligible for COBRA coverage are called "qualified beneficiaries". The events which entitle them to coverage are called qualifying events. In addition, a child born to, adopted by, or placed for adoption with the covered employee during the continuation coverage will be a qualified beneficiary for COBRA purposes. To be a qualified beneficiary for a specific type of health coverage, you must have had that particular coverage under the Plan on the day before a qualifying event occurs.

See the chart below which summarizes who is eligible for continuation coverage under COBRA, under what circumstances, and for how long.

***Who Must Provide Notice When Coverage is Lost***

When a qualifying event occurs, you and the University have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of Dependent status, **you or a covered family member must notify the University in writing within 60 days of the qualifying event.** The University will know if the event is your death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

When the University is notified or learns of a qualifying event, the University will send you and/or your Dependent(s) a written explanation of the right to elect continuation coverage. **You then have 60 days from the latter of the date of this explanation from the University or the date on which your existing coverage would end to notify the University of your election.** If you and/or a Dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Employee	Reduction in hours of employment	18 months*
	Termination of employment for reasons other than gross misconduct	18 months*
Covered Spouse or Domestic Partner of an Employee	Death of employee	36 months
	Divorce or legal separation from employee	36 months
	Employee becomes entitled to Medicare (Part A or B or both)	36 months
	Reduction in employee's hours of employment	18 months*
	Termination of employee's employment for reasons other than gross misconduct	18 months*
Covered Dependent Child	Death of employee	36 months
	Divorce or legal separation of employee and spouse	36 months
	Failure of child to qualify as a Dependent under the Plan	36 months
	Employee becomes entitled to Medicare (Part A or B or both)	36 months
	Reduction in employee's hours of employment	18 months*
	Termination of employee's employment for reasons other than gross misconduct	18 months*
* The 18-month continuation coverage period will be extended to 29 months for all qualified beneficiaries who are disabled under the Social Security laws at any time during the first 60 days of COBRA coverage. <b>To qualify for this extension, the qualified beneficiary must notify the University within 60 days of the federal agency determination that s/he is disabled under the Social Security laws and before the expiration of the 18-month period.</b> The University is permitted to charge a higher premium for continuation coverage during the 19th through 29th months. If the employee finds that s/he is no longer disabled, s/he must notify the University within 30 days of such a determination.		

The 18, 29, or 36 months of continuation coverage begins on the date that coverage would initially end.

***If You Elect to Continue Coverage***

Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one member of the family may make an election that covers some or all of the others.

If you elect to continue coverage, you must pay a total premium equal to the cost to the Plan of such coverage, plus a two percent (2%) monthly administration charge (or such higher charge as may be permitted by law). The total premium includes the University's contribution and any

contribution an active participant is required to make under the Plan. Please contact the University's Benefits Services Division at (202) 994-9620 for more information on premium cost.

**The first payment for continuation coverage must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for each month after your election are due by the 1st day of the month and must be paid within a 30-day grace period beginning on that date, or your COBRA continuation coverage will terminate.**

Premium rates will change periodically for all qualified beneficiaries if costs to the University change.

Continuation coverage will be identical to the coverage provided to similarly-situated employees and/or Dependents. Your health care coverage will continue to be provided by the insurer or other provider that is providing benefits to you on the date of the qualifying event. Should benefit levels increase or decrease, or should coverage change in any way, both active and COBRA participants will experience the same change.

### ***Coverage for Eligible Dependents***

If you elect continuation coverage that also covers your eligible Dependents, these Dependents may not make an independent selection of coverage until the next annual open enrollment period. At that time, they may change their coverage if they wish.

However, if you continue some, but not all, of the coverages to which you are entitled, or if you decide not to continue your own coverage at all, each eligible Dependent for whom you do not elect continuation coverage may make his/her own coverage selection, independent from your election.

### ***Changes to Continuation Coverage***

Qualified beneficiaries have the same opportunities to change coverage as active employees during each annual open enrollment period. During each annual open enrollment period, you may elect different coverage or add or delete Dependents in the same manner as an active employee.

### ***When COBRA Benefits End***

Generally, continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart above. However, COBRA benefits will end immediately if:

- the person whose coverage is being continued fails to pay the premium on time;
- the person whose coverage is being continued becomes, after the date of the election of continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation which does not apply to (or is satisfied by) the person under applicable provisions of federal law);
- the person whose coverage is being continued becomes, after the date of the election of continuation coverage, entitled to Medicare benefits;

- in the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the person is no longer disabled under the Social Security laws; or
- the University no longer maintains a group health plan covering any employee.

***Extended Coverage***

An 18-month period of continuation coverage may be extended if another qualifying event occurs during that time. However, no one may extend coverage for more than 36 months from the occurrence of the first qualifying event. For example, if your employment ends and you divorce during the initial 18-month continuation period, your Dependents (but not you) may extend coverage for up to 36 months from the date your employment ended. Under another special rule, if the covered employee becomes entitled to Medicare benefits and during the subsequent 18-month period loses coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than the employee will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement, subject to the rules regarding earlier termination of COBRA coverage.

***Continuation Coverage During Military Service***

Employees and Dependents who lose health coverage due to the employee’s military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue coverage for up to 18 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

***Conversion to an Individual Policy***

At the end of the 18, 29, or 36 month continuation period, you may be eligible to convert your medical coverage to an individual policy. If you are eligible, you will be sent information explaining your option to convert to an individual policy before the continuation period expires.

**PLAN ADMINISTRATOR**

The Plan Administrator is the University. The name, business address, and business telephone number of the University are provided under the section below entitled **ADDITIONAL INFORMATION** (page 37).

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 the authority to make decisions under the Plan relating to benefit claims to CIGNA. CIGNA is the sole judge of all benefit claims under the Plan. Benefits under the Plan will be paid only if CIGNA decides in its discretion that the applicant is entitled to them.

The decisions of the CIGNA or the Plan Administrator in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

## **PLAN AMENDMENT OR TERMINATION**

The University reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees (including retirees) and their Dependents. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease employee contributions, (3) increase or decrease deductibles and/or co-payments, (4) change the class(es) of employees and/or Dependents covered by the Plan, and (5) change insurers, or other providers. The University may also make certain administrative changes to the Plan and amendments to the benefits provided under the Plan. The University also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination, or partial termination.

## **ADDITIONAL INFORMATION**

Plan Sponsor and Plan Administrator	The George Washington University 2121 Eye Street, NW Washington, DC 20052 (202) 994-1000
Employer Identification Number	53-0196584
Plan Name	The George Washington University Health Insurance Plan
Plan Identification Number	501
Plan Year	January 1 – December 31
Type of Plan	The Plan is a welfare plan providing health insurance benefits
Claims Administration and Funding	The Plan is self-insured. Benefit claims are paid out of the general assets of the University and administered in accordance with a contract between the University and CIGNA(CIGNA Healthcare, PO Box 5200, Scranton, PA 18505-5200, (800) 244-6224).
Agent for Service of Legal Process	The George Washington University 2100 Pennsylvania Avenue, NW Suite 250 Washington, DC 20052 ATTN: Dennis H. Blumer Vice President and General Counsel
Plan Contributions	Contributions are paid by the George Washington University and Plan participants.

## **LOSS OF BENEFITS**

Except as might otherwise be described in this SPD or other Plan booklets, your coverage ends when your employment with the University terminates (unless you are covered by the Plan as a retiree). This will occur upon your retirement, resignation, discharge, or death. The University will, however, discuss with you at your request what, if any, arrangements may be made to continue coverage beyond the date your employment ceases. The section entitled **CONTINUATION OF COVERAGE UNDER COBRA** (page 33) also describes certain circumstances under which health care coverage may be continued after the date your employment ends, or, in the case of your Dependents, after the date on which they become ineligible for health care coverage under the Plan.

## **STATEMENT OF ERISA RIGHTS**

As a participant in George Washington University Health Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to:

### ***Receive Information About Your Plan and Benefits***

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 health care coverage for yourself or your Dependents, as that term is defined in the section entitled “Dependents” (pages 2-3), if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. *Note that although ERISA does not provide for continuation coverage for domestic partners, the Plan provides this coverage for domestic partners, as described in the section entitled CONTINUATION OF COVERAGE UNDER COBRA (page 33).*
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it

up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### ***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 the employee benefit plan. 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 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### ***Assistance With Your Questions***

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, 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 Avenue 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.

## **FOR YOUR REFERENCE**

- Member Services Representatives are available to answer PPO benefit and claim inquiries Monday through Friday from 8:00 a.m. until 6:00 p.m., Eastern Time. In addition, a

Voice Response Unit (VRU) is available 24 hours a day and seven days a week for claims status and claim form requests. Please call Member Services at (800) 244-6224.

- You can also send written inquiries to CIGNA at:
  - CIGNA Healthcare
  - PO Box 5200
  - Scranton, PA 18505-5200
- For questions regarding the Prescription Drug Program, you may call CareMark at (800)-241-3371 Monday through Friday from 8:00 a.m. until 10:00 p.m., and Saturday from 9:00 a.m. until 5:30 p.m. Eastern Time.
- For other inquiries regarding your health insurance coverage, you may contact University's Benefit Services Division at (202) 994-9620.
- You may also send inquiries to:
  - The George Washington University
  - Human Resource Services, Benefit Services Division
  - Suite 220
  - 2033 K Street, NW
  - Washington, DC 20052