

Faculty & Staff
Benefits Manual
December 2023

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1.0 Introduction

Eligible faculty and staff members of American University receive a valuable and comprehensive package of benefit plans and programs. The American University Faculty Staff Benefits Manual provides extensive information concerning the major provisions of each benefits plans. You should refer to the appropriate sections of the benefits manual, or the official plan documents, for comprehensive information concerning your benefit plans, including your eligibility to participate in them.

In the event of any conflict between the appropriate descriptive sections of this Faculty & Staff Benefits Manual and the official plan documents, the plan documents will govern.

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided, the eligibility rules, or any other feature of the plan. Your participation in the university's benefits program does not guarantee your employment with the university for any length of time.

2.0 Medical Benefits

2.1 Introduction

Medical insurance is one of the most valuable benefits that you can provide for yourself and your family. Eligible faculty and staff members of American University have a choice of two medical plan options in the university's group health plan. These options offer you a choice of coverage under a point-of-service (POS) plan or a health maintenance organization (HMO).

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided, the eligibility rules, or any other feature of the plan. Your participation in the university's benefit program does not guarantee your employment with the university for any length of time.

2.2 Medical Plan Eligibility and Participation

Participation in the university's medical benefit program gives you a number of important advantages:

- the option to participate in either the CareFirst BlueChoice Advantage plan, or the Kaiser Permanente HMO;
- a wide range of covered services under each plan;
- coverage for your eligible dependents;
- a pre-tax contribution feature;
- the flexibility to change your medical plan election once each year.

2.3 Eligibility

You are eligible to participate in the medical benefit program if you are:

- a full-time faculty member; or
- a regular, full-time staff member.

Full-Time Faculty Member

You are considered to be a full-time faculty member if:

- you currently have a contract as a full-time faculty member and are receiving remuneration; or
- you have a nine-month contract, are receiving remuneration, and have been appointed for the upcoming fall semester.

Regular, Full-Time Staff Member

You are considered to be a regular, full-time staff member if your position is classified as full-time and you are scheduled to work for at least 28 hours per week.

You are not eligible for participation in the medical benefit program if you are working on a part-time or temporary basis. If you are not certain about your eligibility for participation, please contact the Benefits Team in the Office of Human Resources.

Coverage for Eligible Dependents

In addition to covering yourself, you may elect to cover your eligible dependents. Your eligible dependents are:

- your spouse, opposite-sex domestic partner, or same-sex domestic partner;
- your unmarried dependent children up to the end of the calendar year in which they reach age 26;
- your unmarried dependent children over age 26 who are incapable of supporting themselves due to a mental or physical disability (provided that this disability occurred before the date that the child reached age 26). You must provide the appropriate certification of disability in order to qualify for this extension.

Adopted or Foster Children

For plan purposes, the term “children” includes the children of either parent, adopted children, or children who are in the process of being adopted and are placed in the home of a family who plan to adopt them. The term “children” also includes children who are your financial responsibility and for whom you or your spouse has been appointed legal guardian.

Spouse

For plan purposes, the term “spouse” refers to the legal spouse of the employee.

Domestic Partner

For plan purposes, “domestic partners” refers to persons of the opposite or same gender who have a completed and document-supported [Domestic Partner Affidavit](#) on file with human resources.

In addition to covering yourself, you may elect to cover your eligible dependents. Your eligible dependent is registered as your domestic partner, civil union partner, or reciprocal beneficiary with a government agency where such registration is available. They also can certify that they are:

- at least 18 years of age and mentally competent to consent to a legally binding contract;
- are your sole domestic partner and intend to remain in this relationship indefinitely;
- share a close, personal relationship and you are both responsible for each other’s welfare;
- share the same primary residence (and have shared this residence for the past twelve months) and intend to do so indefinitely;
- are not married to anyone of the same or opposite sex nor have had another domestic partner within the past twelve (12) months;
- are not related by blood closer than would bar marriage in the District of Columbia or the state they live in;
- are financially interdependent with you; and
- are able to demonstrate joint responsibility with you for each other’s common welfare and financial interdependence for a minimum of 12 months preceding the submission of the [Domestic Partner Affidavit](#).

Coverage Levels

You may choose one of the following levels of coverage for medical benefits:

- individual only; or
- individual plus one coverage; or
- family coverage.

Cost

You and the university share the cost of your medical coverage. Your share of the cost will depend on your salary, the medical care option you select, and the level of coverage you choose. For information on additional cost sharing provisions, please refer to [The CareFirst BlueChoice Advantage Plan](#) and [Kaiser Permanente](#).

Pre-Tax Contributions

Pre-tax contributions give you a real advantage because these contributions come out of your pay before federal, Social Security, and (in most cases) state and local taxes are applied. Since your pre-tax contribution is not included as income on your W-2 earnings statement, it will reduce your taxable income.

Your pre-tax contributions for a given year will reduce your Social Security wage base for that year. This may result in a slight reduction in your Social Security benefits when you retire.

In certain circumstances, you can make pre-tax contributions on behalf of an opposite-sex or same-sex domestic partner. Please contact the HR benefits team for more information.

How to Enroll

In the fall of each year, the university sponsors an annual open enrollment period, during which you can:

- select the medical plan option in which you want to participate;
- change your level of coverage (for example, from individual only to family coverage);
- add and remove dependents from your coverage; or
- elect to waive coverage (see [Waiving Coverage](#)).

If you do not enroll before the end of the applicable open enrollment period and you are not required to make an election, your current medical plan elections will stay in effect for the next calendar year. You may not make an election outside of open enrollment until the next annual open enrollment period, unless you have a change in family status (see [Changing Coverage during the Year](#)).

New Faculty or Staff Members

New faculty or staff members who are eligible to participate (see 2.2 Medical Plan Eligibility and Participation) may enroll for health care coverage during their first 30 days of full-time employment with the university. This coverage will become effective on the first day of the month following your date of hire. (If your date of hire is the first day of the month, your coverage will be effective on that day.)

For example, assume that you are hired on August 18 of a given year. Your health care coverage will begin on September 1, provided that you enroll on a timely basis.

If you do not enroll within 30 days of your date of hire, you will not be eligible for medical coverage for the remainder of the calendar year. You may not make a medical plan election until the next annual open enrollment period unless you have a qualifying change in your family status (see below).

Changing Coverage during the Year: Open Enrollment and Qualifying Events

You may make a change to your coverage during open enrollment or when you have a qualifying or HIPAA special enrollment event.

Open enrollment offers employees the one opportunity each year to change their elections for health, dental, group legal insurance, flexible spending accounts, and optional life and accidental death & dismemberment (AD&D) insurance. At other times of the year, faculty and staff can make changes to their benefits only if they have a qualifying event or an event that is covered under the HIPAA special enrollment provisions. Qualifying events include the following circumstances:

- marriage, divorce, legal separation, termination of domestic partnership;
- death of a spouse, domestic partner, or dependent;
- birth or adoption of a new dependent or gaining legal custody of a new dependent;
- a change in a dependent's eligibility status;
- a change in your employment status or that of your spouse or domestic partner; or
- a change of your residence (only pertinent if the move causes you to reside outside of your medical plan's network service area).

Changing Coverage during the Year: HIPAA Special Enrollment

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the other 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Benefits Team in the Office of Human Resources.

If you have a qualifying event or HIPAA special enrollment event and wish to change your benefits, you must submit supporting dated documentation and enroll within 30 days of the qualifying event. Please note that the change to benefits must be consistent with the event that occurred.

Faculty Leave

The university's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research leave or sabbatical leave are considered to be on full-time, active status while on leave. Therefore, your coverage will continue during your leave, as long as you continue to make the required contributions towards the cost of your benefits.

Leave without Pay

Eligible faculty and staff members who take leave without pay may be permitted to continue certain portions of their benefits coverage at their own expense. You should contact the human resources faculty coordinator for more information concerning the continuation of your coverage if you take leave without pay.

2.4 Understanding Your Medical Care Options

Eligible faculty and staff members can elect one of the following medical plan options:

- the CareFirst BlueChoice Advantage plan;
- the Kaiser Permanente HMO; or
- no medical coverage (Waiving Coverage).

CareFirst BlueChoice Advantage Plan

The CareFirst BlueChoice Advantage Plan is a “Point of Service” plan that allows you to receive in-network care from the CareFirst BlueChoice, BluePreferred PPO, or BlueCard national PPO networks of providers or out-of-network care from any provider (at a higher cost).

Refer to the [The CareFirst BlueChoice Advantage Plan](#) for a complete description of the plan option.

Kaiser Permanente HMO

Kaiser Permanente is the oldest Health Maintenance Organization (HMO) in the country. When you enroll in Kaiser Permanente, you and your eligible dependents will have access to a full range of Kaiser Permanente medical services on a prepaid basis.

Refer to [Kaiser Permanente](#) for a complete description of the plan option.

Waiving Coverage

You should carefully consider your other sources of medical coverage before deciding to waive medical coverage.

If you waive medical coverage due to your coverage under another medical plan, you may elect to transfer to a university-sponsored plan:

- during the next annual open enrollment period; or
- within 30 days of the date that you have a [qualifying event](#) in family status.

2.5 The CareFirst BlueChoice Advantage Plan

The CareFirst BlueChoice Advantage plan is a Point-of-Service (POS) plan that allows you maximum flexibility when choosing your health care providers. You make your choice for in-network or out-of-network coverage based on the doctor you choose to see and whether they are in the CareFirst BlueChoice, BluePreferred PPO, or BlueCard PPO networks.

Each time you or an eligible dependent needs medical care, you can choose the:

- in-network option for CareFirst BlueChoice, BluePreferred, or BlueCard providers; or the

- out-of-network option for all other providers.

Choosing CareFirst BlueChoice Advantage

With some exceptions, the CareFirst BlueChoice Advantage plan covers the same broad range of medical services in- and out-of-network. In general, it will cost you less to use the in-network option, because the participating providers in the CareFirst BlueChoice network have agreed to accept direct payment from the plan for covered medical services. You automatically have access to in- and out-of-network benefits by enrolling in CareFirst BlueChoice Advantage. How much you pay when you see your doctor is driven by whether or not your doctor participates in the networks noted above.

CareFirst BlueChoice Advantage Coverage Overview		
	In-Network	Out-of-Network
Choice of Physician	You may use any provider in the CareFirst BlueChoice, BluePreferred PPO, or BlueCard PPO networks. Open Access feature: No referrals are required to see a specialist.	You may choose any physician. There are no network limitations. No referrals are required.
Annual Deductible	\$400 Individual \$800 Individual Plus One \$800 Family NOTE: The in-network deductible applies to non-preventive care services. Preventive care such as annual physical and mammograms are not subject to the deductible or copayments.	\$1,000 Individual \$2,000 Individual Plus One \$2,000 Family
Copayments	\$20 Primary care \$40 Specialist	Not applicable (see coinsurance)
Coinsurance	90% of plan allowance paid by the health plan. 10% paid by participant once annual deductible is met.	65% of plan allowance paid by the health plan. 35% paid by participant once annual deductible is met.

CareFirst BlueChoice Advantage Coverage Overview		
	In-Network	Out-of-Network
Maximum Out-of-Pocket Expense	\$2,750 Individual \$5,500 Individual Plus One \$5,500 Family Note: The in-network benefit does not cover any portion of your medical bills until you first meet your annual deductible; copayments for non-preventive care still apply and do not count toward the deductible. After the deductible is met for the year, you pay only the copayment or coinsurance, if applicable. If you reach the maximum out-of-pocket expense for the year, the plan pays 100% of plan allowance(s) for covered expenses for the remainder of that year. Example: With individual coverage you first pay the \$400 deductible and office visit copayment for non-preventive care. Then, copayments or other cost-sharing applies. If your out-of-pocket expense totals \$2,750, the plan pays 100% of plan allowance(s) for the remainder of the year.	\$4,000 Individual \$8,000 Individual Plus One \$8,000 Family
Claim Forms	No claim forms to file.	May need to file your own claims.
Pre-Certification	Hospital certifications arranged by physicians.	You are responsible for arranging your own hospital certifications. Financial penalty if pre- certification is not arranged.

How the CareFirst BlueChoice Advantage Plan Works.

The plan is administered by CareFirst and offers a comprehensive network of participating doctors, hospitals, and other health care providers through the CareFirst BlueChoice, BluePreferred PPO, and the national BlueCard PPO network. The participating providers are located throughout the Washington, D.C., metropolitan area.

Keep in mind that the choice of using in-network or out-of-network care is entirely up to you. You can make this choice each time you or an eligible dependent needs medical care.

- If you use the in-network option, your participating network provider will submit your claims

for you. This means that:

- you pay no copayment for preventive care, a copayment or coinsurance for non- preventive care, and a one-time annual deductible for most covered services;
- you do not have any claim forms to complete;
- your *hospital certification* will be arranged by your physician; and your out-of-pocket expenses will (in most cases) be lower.

Selecting a Primary Care Provider

The BlueChoice Advantage plan does not require you to designate a Primary Care Provider (PCP). However, we recommend that you select a Patient Centered Medical Home (PCMH) PCP to provide comprehensive care coordination.

Referrals are not required to any in-network specialist including OB/GYNs under the CareFirst BlueChoice Advantage plan.

In-Network Annual Deductible

The annual deductible is the amount you pay before your benefits begin. The annual deductible for in-network benefits is \$400 per person (subject to the maximums outlined below). This deductible applies only once during the calendar year, even though you or another covered person may have several different injuries or illnesses during the year.

The maximum amount of your annual in-network deductible depends on your level of coverage:

<u>Level of Coverage</u>	<u>Maximum Annual Deductible</u>
Individual	\$400 per person
Individual Plus One	\$800 (maximum of \$400 per person)
Family	\$800 (maximum of \$400 per person)

Once any combination of deductible expenses reaches the limit in a calendar year, the annual deductibles for all covered persons will be waived for the rest of that year. Copayments or coinsurance will continue to apply even once the deductible is met.

The in-network deductible applies to the in-network benefits only. There is a *separate annual deductible that applies to out-of-network expenses*. The annual deductible and out-of-pocket payment limit for the in-network benefit are subject to change.

How the Out-of-Network Benefit Works

- For the out-of-network benefits:
- you can choose any doctor you want for your care;
- you pay coinsurance and a one-time annual deductible for most covered services
- you must satisfy the *annual deductible* before your benefits begin;
- you must obtain a *certification before a hospital admission*; and
- if your doctor or hospital is not a CareFirst or BlueCross BlueShield participating provider, you must file a claim form in order to receive your benefits.

Out-of-Network Annual Deductible

The annual deductible is the amount you pay before your out-of-network benefits begin. The out-of-network annual deductible is \$1,000 per person (subject to the maximums outlined below). This deductible applies only once during the calendar year, even though you or another covered person may have several different injuries or illnesses during the year.

The maximum amount of your annual out-of-network deductible depends on your level of coverage:

<u>Level of Coverage</u>	<u>Maximum Annual Deductible</u>
Individual	\$1,000 per person
Individual Plus One	\$2,000 (maximum of \$1,000 per person)
Family	\$2,000 (maximum of \$1,000 per person)

Once any combination of deductible expenses reaches the above limit in a calendar year, the annual deductibles for all covered persons will be waived for the rest of that year.

For example, suppose you have family coverage and you have a \$900 covered medical expense during January of a given calendar year. Also assume that your spouse has a \$600 expense in March, and your child has a \$500 expense in June. Since these expenses add up to \$2,000, you do not have to pay any additional annual deductibles for the rest of the calendar year.

Out-of-Pocket Limit

- For the out-of-network benefit, there is a limit on the amount you have to pay for covered expenses during the calendar year. This limit applies to all covered expenses except the following:
- charges for prescription drugs purchased under the prescription drug program;
- *charges for services that are not covered by the plan or charges that exceed the applicable Plan Allowance.*

The annual out-of-pocket payment limit for out-of-network care is \$4,000 per person (subject to the additional limits outlined below). Once the out-of-pocket expenses for a covered person reach this limit in a given calendar year, the plan will pay 100 percent of the plan allowance for that person's additional covered expenses for the rest of the calendar year.

The maximum amount of your annual out-of-pocket expenses depends on your level of coverage:

<u>Level of Coverage</u>	<u>Maximum Out-of-Pocket</u>
Individual	\$4,000
Individual Plus One	\$8,000
Family	\$8,000

Once any combination of your covered out-of-pocket expenses reaches the maximum annual limit in a calendar year, the plan will pay 100 percent of plan allowance of additional covered expenses for the rest of that year. No individual may contribute more than their \$4,000 limit in any year to the family maximum.

For example, suppose you have individual plus one coverage and you have \$2,500 in covered out-of-pocket expenses during March of a given calendar year. Also assume that you have an additional \$5,500

out-of-pocket expense for your spouse in April. Since these out-of-pocket expenses add up to \$8,000, the plan will pay 100 percent of any additional covered expenses that you and your spouse have for the rest of the calendar year.

The out-of-network annual deductible and out-of-pocket payment limit are subject to change.

Utilization Management

Utilization management is designed to help you and your doctor by encouraging necessary and appropriate treatment. The components of this program include:

- pre-admission and admission review;
- continued stay review;
- case management; and
- mental health and substance abuse care review.

Preadmission and Admission Review

You must obtain a preadmission and admission review before you are admitted to the hospital for out-of-network benefits. This includes reviews for hospital admissions for inpatient medical, surgical, and maternity care. Certification for admission must be obtained at least five business days before an elective or planned admission. Special rules also apply for [*mental health care admissions*](#).

If you do not obtain a preadmission and admission review by CareFirst before hospital admission for out-of-network benefits, your benefits may be reduced by 50 percent. The notification may be oral, with written notification to follow within three days.

How to Obtain a Review

The preadmission and admission review procedure is easy and convenient. In an elective or planned admission, in a non-emergency situation, you should call the number shown on your identification card before you or the eligible dependent is scheduled for an inpatient hospital admission for out-of-network benefits. This call also may be made by a family member, your doctor, or a hospital representative.

After you make the call, a CareFirst health care professional will review your doctor's recommendation for hospital admission and, if necessary, contact your doctor for more information concerning the proposed course of treatment.

In most cases, you, your doctor, and the hospital will be notified of the decision to certify the admission within 24 hours.

Emergency Care

If you or an eligible dependent are admitted to the hospital in an emergency, you should call 1-866-773-2884 within 24 hours of being admitted to the hospital. This call also may be made by a family member, your doctor, or a hospital representative.

See [*Emergency Care*](#) for other special rules that apply for emergency care when you are out of the area.

Continued Stay Review

Continued stay review takes place after an inpatient hospital admission. The continued stay review assists your doctor in determining if additional inpatient hospital days are medically necessary.

CareFirst will monitor your progress periodically towards hospital discharge under the continued stay review program. CareFirst also will consult with a doctor who recommends that your length of stay be extended beyond the number of approved days. If CareFirst does not approve this extension, you may be responsible for any additional hospital charges.

Case Management

Case management is a service which helps to coordinate home care services and identify long-term care treatment situations. If special benefits are required, case management may recommend alternative levels of care, such as skilled nursing facilities, home health care, or hospice care.

Mental Health and Substance Abuse Care

All inpatient mental health and substance abuse treatment that are received under the CareFirst BlueChoice Advantage plan requires a pre-certification review. This review is provided through CareFirst Behavioral Health. To obtain the necessary certification, you, your doctor, or a member of your family should call 1-800-245-7013.

The call to CareFirst Behavioral Health should be made before a non-emergency hospital admission under the CareFirst BlueChoice Advantage plan takes place. In an emergency, this call should be made within 24 hours after the emergency admission takes place. This call may be made by you, a family member, your doctor, or a hospital representative.

CareFirst will review and evaluate outpatient mental health and substance abuse services to assess the medical necessity and appropriateness of the service.

Covered Medical Expenses

Covered medical expenses are expenses that are eligible for payment under the CareFirst BlueChoice Advantage plan. The following sections contain charts and descriptions of each major category of covered expense under the plan.

As you read these sections, please remember that the level of payment for your covered medical expenses will vary, depending on whether you use the in-network benefit or the out-of-network benefit. In addition, this summary does not contain all of the details about covered medical expenses. If you need more information concerning these expenses, please contact CareFirst at 1-800-628-8549 or go to www.carefirst.com.

How Plan Payments are Determined

The amount that the CareFirst BlueChoice Advantage plan will pay for a given covered service is determined by the Plan Allowance for that service. The plan allowance for each covered service is determined by:

- the contracted rate or fee schedule that participating providers have agreed to accept for that

service; or

- the rate or fee that is established by law (if applicable).

If the amount that a non-participating provider charges for a covered service is greater than the plan allowance for that service, you will be responsible for paying the difference.

There may be circumstances in which you receive services from a provider who participates in another BlueCross BlueShield plan (for example, while on vacation). In this case, the participating provider will file your claim based on the other plan’s payment provisions.

If you receive an out-of-area service from a provider who does not participate in BlueCross Blue Shield, the plan payment will be based on the Plan Allowance for that service. Regardless of how services are received, you still will be responsible for paying any applicable deductibles, copayments, or coinsurance amounts.

If you have any questions concerning the plan allowance for a covered service or procedure, you can contact CareFirst at 1-800-628-8549.

Care Received Outside the Washington, DC Area

If you or your one of your covered family members are outside the Washington, DC area and need medical care, you can access in-network benefits through the BlueCard network. To find a provider, visit www.carefirst.com.

Hospital Care

This section describes covered expenses for inpatient hospital admissions and inpatient physician care under the CareFirst BlueChoice Advantage plan. Please note that all hospital admissions that are not coordinated through your CareFirst BlueChoice Primary Care Provider will be covered under the out-of-network benefit option and must be certified through the *Utilization Management* Program. If you do not obtain a preadmission and admission review by CareFirst before a hospital admission for out-of-network benefits, your benefits may be reduced by 50 percent.

CareFirst BlueChoice Advantage Hospital Coverage Overview		
Service	In-Network	Out-of-Network All services must be authorized
Medical, Surgical, Obstetrical	90% coverage – after \$250 copayment when admitted by a CareFirst BlueChoice Advantage physician to an approved hospital only at approved locations. Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible (pre-certification is required).
Rehabilitative admission (not related to alcohol and drug abuse treatment and rehabilitation)	After \$250 copayment covered for up to 30 days per confinement in an acute care CareFirst BlueChoice Advantage hospital when hospitalization is medically necessary and authorized by CareFirst. Subject to deductible.	Not covered.

CareFirst BlueChoice Advantage Hospital Coverage Overview		
Service	In-Network	Out-of-Network All services must be authorized
Preadmission Testing	90% coverage – at approved locations. If testing requires a hospital stay, \$250 copayment applies. Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible for diagnostic testing, x- rays, and lab work when rendered in the outpatient department of a hospital.
Inpatient Physician Visits for Medical/Surgical Services	90% coverage for a CareFirst BlueChoice Advantage provider approved admission. Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible.
Inpatient Specialist Care	90% coverage for an approved admission. Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible.
Inpatient Consultation	90% coverage for an approved admission. Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible.

The plan covers semi-private room and board charges for an unlimited number of days.

Charges for a private room are not covered, unless:

- a semi-private room is not available at time of admission; or
- you must be isolated to prevent contagion; or
- the law requires isolation due to communicable disease or infection.

If a semi-private room is not available when you are admitted but you are offered a semi-private room after your admission and you choose not to be moved, you will be responsible for paying the difference between the hospital’s semi-private and private room rates.

Special limitations apply in the case of [*mental health care or substance abuse care*](#).

The plan also covers a wide range of other hospital services, including:

- operating, recovery, delivery, intensive care, cystoscopic, and other specialized hospital rooms;
- routine nursery care for a newborn baby while the mother is hospitalized for covered maternity care;
- anesthesia, oxygen, and drugs provided by the hospital during an inpatient stay;
- general nursing care;
- artificial heart and kidney machines;
- hospital lab, X-ray, and machine tests;
- sterile tray service, dressings, and plaster casts;
- blood handling, sera (including blood, blood plasma and blood expanders);
- transgender procedures (subject to \$400,000 lifetime maximum).

The out-of-network benefits are limited to the following inpatient doctor visits, consultations, and referrals:

- intensive care which requires a doctor’s attendance; and
- consultation by another doctor due to the complexity of the patient’s condition.

The out-of-network benefit does not pay for inpatient doctor visits for diagnostic, convalescent, custodial, or institutional care, or care which is for rest, rehabilitation, or occupational, speech, or physical therapy.

Private Duty Nursing

Private duty nursing is covered only when medically necessary and authorized by CareFirst for an approved admission.

CareFirst BlueChoice Advantage Private Nursing Overview		
Service	In-Network	Out-of-Network
Inpatient Private Duty Nurse (services must be performed by an RN or LPN)	90% coverage after annual deductible is met when authorized by plan for an approved admission due to medical necessity.	Not covered.
Outpatient Private Duty Nurse (services must be performed by an RN or LPN)	Not covered.	65% of plan allowance charge – after you’ve met the annual deductible. Benefits are limited to a maximum of two hours a day (1 visit) up to 50 visits per calendar year.

Emergency Care

This section describes covered expenses for emergency care under the CareFirst BlueChoice Advantage Plan.

CareFirst BlueChoice Advantage Emergency Care Overview		
Service	In-Network	Out-of-Network
In-Plan Area	90% coverage – after \$100 copayment per visit for bona fide emergency. \$100 is waived if admitted as an inpatient to the hospital. Subject to deductible.	90% coverage – after \$100 copayment per visit for bona fide emergency. \$100 is waived if admitted as an inpatient to the hospital. Subject to deductible.
Outside Plan Area	Same coverage as in-plan area.	Same coverage as in-plan area.
Ambulance Services	90% coverage for ground ambulance to hospital for authorized emergency. Subject to a deductible.	65% of plan allowance, after you’ve met the deductible

If you have a medical emergency or accidental injury, you can seek treatment at the nearest hospital. If doing so would not jeopardize your health, you should call the emergency assistance number on your identification card before seeking care.

A bona fide emergency is a medical emergency or an accidental injury that requires immediate medical attention. Some examples of bona fide emergencies include heart attack, poisoning, severe breathing

difficulty, convulsions, and other acute conditions.

A claim for treatment of a condition that is not a bona fide emergency (including ambulance service) will be paid in-network at 75 percent of covered expenses, with no deductible applied and for out-of-network at 75 percent after the deductible. This would apply, for example, if you use the hospital emergency room for care that could have been provided at an urgent care center or your doctor's office.

If you or an eligible dependent is admitted to the hospital in an emergency, you should call the emergency assistance number shown on your identification card within 24 hours after admission to the hospital. (This call also may be made by a family member, your doctor, or a hospital representative.)

Surgical Care

This section describes covered expenses for surgical care under the CareFirst BlueChoice Advantage plan.

CareFirst BlueChoice Advantage Surgical Care Overview		
Covered Service	In-Network	Out-of-Network All services must be authorized
Outpatient Surgery	Primary Care Provider: 100% coverage – after \$20 per visit copayment. Subject to deductible for non-preventive care services. Specialist: 100% coverage – after \$40 per visit copayment. Subject to deductible. Facility: 90% coverage subject to deductible.	65% of plan allowance – after you've met the annual deductible (pre-certification is required).
Inpatient Surgery	90% coverage for an approved admission after \$250 copayment. Subject to deductible.	65% of plan allowance – after you've met the annual deductible.
Second Surgical Opinion Consultation	100% coverage – after \$40 per visit copayment. Subject to deductible. Paid in full if requested by CareFirst.	65% of plan allowance charge – after you've met the annual deductible.
Anesthesia Services	Inpatient: 90% coverage. Subject to deductible. Outpatient: 90% coverage. Subject to deductible.	65% of plan allowance – after you've met the annual deductible.
Organ Transplant	90% coverage for limited services. Subject to deductible.	65% of plan allowances for limited services – after you've met the annual deductible.

The plan covers expenses for both inpatient and outpatient surgical care. These covered expenses include:

- operations and aftercare for the treatment of disease, injury, and fractured and dislocated bones;
- anesthesia (anesthesia by acupuncture covered when performed by a licensed/certified provider under the direct supervisor of an M.D.);
- sterilization (benefit for reversal of sterilization are not covered);
- endoscopic procedures for examination of internal organs;
- services as a result of accidental injury and trauma. In the event there are alternative procedures that meet generally accepted standards of professional care for a member's condition, benefits will be based on the lowest cost alternative; and
- CareFirst BlueChoice Advantage plan reconstructive surgery benefits are limited to surgical procedures that are medically necessary, as determined by CareFirst, operative procedures performed on structures of the body to improve/restore bodily function or to correct deformity resulting from disease, trauma, or previous therapeutic intervention.

Oral surgical procedures are limited to:

- medically necessary procedures, as determined by CareFirst to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or extoses, surgical removal of impacted teeth (and related services);
- medically necessary procedures, such as draining abscesses with cellulitis, that are performed on sound natural teeth and supporting structures, lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts and jaws;
- medically necessary procedures as determined by CareFirst, needed as a result of an accidental injury, when your request or the need for oral surgical services is identified in your medical records within 60 days of the accident; and
- surgical treatment for temporomandibular joint syndrome (TMJ) if there is demonstrated evidence of joint abnormality due to an illness.

All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion are excluded.

If two or more covered procedures are performed at the same time out-of-network, your coverage will pay the normal benefit for the primary procedure and a reduced benefit for the other procedures. All procedures must be medically necessary.

CareFirst transplant benefits are limited to transplant of cornea, skin and kidney, liver, or bone marrow for certain diagnoses. Out-of-network benefits for transplants are limited to certain specified procedures, including cornea, kidney, heart-lung, pancreas (when transplanted simultaneously with kidney), heart, single or double lung, bone marrow (certain diagnoses), skin grafting, and liver. All of these procedures must be pre-approved by CareFirst.

You or your doctor should contact CareFirst directly for more information concerning the benefits, covered services, and pre-approval procedures for organ or bone marrow transplants.

Doctor Visits

This section describes covered expenses for doctor visits under the CareFirst BlueChoice Advantage plan.

CareFirst BlueChoice Advantage Doctor Visits Overview		
Service	In-Network	Out-of-Network All services must be authorized
Medical Services/ Physician Office Visits	Primary Care Provider: 100% coverage – after \$20 per visit copayment. Specialist: 100% coverage – after \$40 per visit copayment. Subject to deductible for non-preventive care services.	65% of plan allowance– after you’ve met the annual deductible.
Well Child Care (up to age 18) Includes routine immunizations	Primary Care Provider: 100% coverage.	65% of plan allowance– not subject to deductible.
Routine Physicals	Primary Care Provider: 100% coverage.	Not covered.
Home Physician Visits	Primary Care Provider: 100% coverage – after \$20 per visit copayment. Specialist: 100% coverage – after \$40 per visit copayment. Subject to deductible for non- preventive services. An approved treatment plan is required	65% of plan allowance – after you’ve met the annual deductible. An approved treatment plan is required

CareFirst BlueChoice Advantage in-network benefits cover allergy testing at 100 percent after the deductible. Allergy sera is covered in-network at 90 percent after the deductible. Allergy injections (Allergen Immunotherapy) are covered at 100 percent with no deductible in-network after PCP/ specialist copayment. Out-of-network benefits are limited to 65 percent of the plan allowance of covered expenses after the annual deductible.

Well child care benefits are available for the following covered services from an eligible dependent’s birth to their 18th birthday:

- preventive care visits;
- routine immunizations and boosters; and
- routine laboratory services.

The actual scheduling for covered well care services may be determined by your doctor.

You or your doctor can contact CareFirst for more information concerning covered well child care services, including covered immunizations and laboratory services.

Maternity Care

This section describes covered expenses for maternity care under the CareFirst BlueChoice Advantage plan.

CareFirst BlueChoice Advantage Maternity Care Overview		
Service	In-Network	Out-of-Network All services must be authorized
Inpatient Hospital	90% coverage at approved locations after \$250 copayment. Subject to deductible.	65% of plan allowance– after you’ve met the annual deductible.
Outpatient Hospital	90% coverage at approved locations. Subject to deductible.	65% of plan allowance– after you’ve met the annual deductible.
Physician	100% coverage – after \$40 per visit copayment (up to \$400 copayment per pregnancy). Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible.
Nurse Midwife	100% coverage – after \$40 per visit copayment (up to \$400 copayment per pregnancy. Nurse Midwife must be associated with an approved center). Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible. Benefits may not be available for Nurse Midwife services if already billed by physician.
Birthing Center	100% coverage – after \$40 per visit copayment (up to \$400 copayment per pregnancy, at approved locations). Subject to deductible.	Not covered.
Family Planning/ Fertility	See Diagnostic Services section.	See Diagnostic Services section.

The plan covers the following services for maternity care:

- room and board charges for a medically necessary stay;
- labor and delivery rooms;
- routine newborn care is included while the mother is hospitalized for covered maternity care, provided the mother is a member and eligible for maternity benefits;
- care for a normal pregnancy, complications when delivery does not occur, or ectopic pregnancy;
- caesarian section or miscarriage;
- prenatal and postnatal care; and
- circumcision and routine nursery doctor visits.
- Abortion is covered on the same basis as maternity care, except that:
 - inpatient hospital benefits are available only when it is medically necessary for the abortion to be performed on an inpatient basis;
 - coverage for outpatient reproductive centers is available through CareFirst BlueChoice Advantage in-network only.

As required by the Newborns’ and Mothers’ Health Protection Act, health care plans must allow for a minimum period for a hospital stay for maternity and pediatric care. As a result, you will have coverage for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96- hour hospital length of stay following a cesarean section.

Transgender Care

A detailed summary of benefits is available by calling the Benefits Team in the Office of Human Resources. As this is a benefit that is not commonly covered CareFirst BlueChoice Advantage, please contact the Benefits Team in the Office of Human Resources directly if you have any problems with claims administration related to this benefit. Please note certain transgender-related procedures are not covered.

CareFirst BlueChoice Advantage Transgender Coverage Overview		
Covered Service	In-Network	Out-of-Network
Transgender Care	Covers pre- and post-surgical hormone therapy, surgery if performed by a qualified provider and in conformance with HBGDA standards. Requires pre-authorization. Surgical, hospital, and laboratory benefits subject to \$400,000 lifetime max.	Covers pre- and post-surgical hormone therapy, surgery if performed by a qualified provider and in conformance with HBGDA standards. Requires pre-authorization. Surgical, hospital, and laboratory benefits subject to \$400,000 lifetime max.

Diagnostic Services

This section describes covered expenses for diagnostic services under the CareFirst BlueChoice Advantage plan.

CareFirst BlueChoice Advantage Diagnostic Services Overview		
Service	In-Network	Out-of-Network All services must be authorized
Diagnostic Services	90% coverage only at approved locations. Subject to deductible.	65% of plan allowance – after you've met the annual deductible.
Non-Emergency CT Scans and MRIs	\$40 copayment. Subject to deductible.	65% of plan allowance. Subject to deductible.
Preventive Care Mammography	100% coverage.	65% of plan allowance – after you've met the annual deductible. Limited to: Ages 35-39: one preventive mammogram of both breasts every 5 years. Ages 40-49: one preventive mammogram of both breasts every 2 years. Ages: 50 and above: one preventive mammogram of both breasts every year.

CareFirst BlueChoice Advantage Diagnostic Services Overview		
Service	In-Network	Out-of-Network All services must be authorized
Family Planning/ Fertility	Primary Care Provider: 100% coverage - after \$20 per visit copayment. Subject to annual deductible then 100% of allowed benefit to \$100,000 lifetime maximum. Specialist: 100% coverage - after \$40 per visit copayment. Subject to annual deductible then 100% of allowed benefit to \$100,000 lifetime maximum. Prior authorization is required. Must have fertility exam resulting in diagnosis of infertility. Diagnosis and treatment of infertility including medically necessary, non-experimental artificial insemination and In-Vitro Fertilization (IVF).	Testing provided to determine that a diagnosis for infertility exists and is covered at 65% of plan allowance – after you’ve met the annual deductible. No further benefit available if diagnosis is confirmed.

The plan covers laboratory, x-ray, and machine tests that are billed by inpatient hospital, outpatient hospital department, outpatient physician, independent facility, or independent lab.

The plan covers screening mammography that is billed by a hospital outpatient department, outpatient physician, or independent radiology facility.

The CareFirst BlueChoice Advantage plan pays 100 percent of the plan allowance of covered expenses for pap tests, with no deductible in-and out-of-network.

Many preventive screening tests are covered at 100 percent and are not subject to the deductible.

Therapeutic Services

The plan covers a wide range of therapeutic services. The following chart summarizes this coverage by major category of service.

CareFirst BlueChoice Advantage Therapeutic Services Overview		
Covered Service	In-Network	Out-of-Network All services must be authorized
Inpatient Chemotherapy	90% coverage after \$250 copayment. Subject to deductible.	65% of plan allowance after annual deductible is satisfied (as long as admission is not primarily for chemotherapy) subject to the Preadmission and Admission Review procedure.

CareFirst BlueChoice Advantage Therapeutic Services Overview		
Covered Service	In-Network	Out-of-Network All services must be authorized
Outpatient Chemotherapy (except when orally administered)	Professional Practitioner: 100% coverage after \$40 per visit copayment or \$20 copayment for primary care provider. Subject to deductible. Office: 100% coverage after \$40 per visit copayment or \$20 copayment for primary care provider. Subject to deductible.	65% of plan allowance after annual deductible is satisfied.
Inpatient Hemodialysis	90% coverage after \$250 copayment. Subject to deductible.	65% of plan allowance after you have met the annual deductible (as long as admission is not primarily for hemodialysis) subject to the Preadmission and Admission Review procedure.
Outpatient Hemodialysis	Professional Practitioner: 100% coverage after \$40 per visit copayment or \$20 copayment for primary care provider. Subject to deductible. Office: 100% coverage after \$40 per visit copayment or \$20 copayment for primary care provider. Subject to deductible.	65% of plan allowance after you have met the annual deductible.
Inpatient Radiation Therapy	90% coverage after \$250 copayment. Subject to deductible.	65% of plan allowance after you have met the annual deductible (as long as admission is not primarily for radiation therapy) subject to the Preadmission and Admission Review procedure.
Outpatient Radiation Therapy	Professional Practitioner: 100% coverage after \$40 per visit copayment or \$20 copayment for primary care provider. Subject to deductible. Office: 100% coverage after \$40 per visit copayment or \$20 copayment for primary care provider. Subject to deductible.	Hospital: 65% of plan allowance after you have met the annual deductible. Physician: 65% of plan allowance after you have met the annual deductible.

CareFirst BlueChoice Advantage Therapeutic Services Overview		
Covered Service	In-Network	Out-of-Network All services must be authorized
Inpatient Respiratory, Speech, and Occupational Therapy	Hospital: 90% coverage after \$250 copayment for non-rehabilitative admission; 30 days for rehabilitative admission. Subject to deductible.	Hospital: 65% of plan allowance after you have met the annual deductible (as long as admission is not primarily for therapy) subject to the Preadmission and Admission Review procedure. Physician or Therapist: 65% of plan allowance after you have met the annual deductible.
Outpatient Respiratory, Speech, and Occupational Therapy	Hospital: 90% coverage if procedure can be performed only in hospital which must be approved. Subject to deductible. Physician or Therapist: 100% coverage after \$40 copayment per visit for short term care. (Short term care means significant improvement is expected within 90 days.). Subject to deductible.	Hospital: 65% of plan allowance charge after you have met the annual deductible. Physician or Therapist: 65% of plan allowance after you have met the annual deductible.
Outpatient Cardiac Rehabilitation	100% coverage. Subject to deductible. Benefits limited to 90 visits	65% of plan allowance after you have met the annual deductible. (must have approved treatment plan; benefits limited to 90 visits)

Medical Supplies

This section describes covered expenses for medical supplies under the CareFirst BlueChoice Advantage Plan.

CareFirst BlueChoice Advantage Medical Supplies Overview		
Service	In-Network	Out-of-Network All services must be authorized
Durable Medical Equipment	90% of plan allowance. Subject to deductible.	65% of plan allowance after you have met the annual deductible.
Hearing Aids	Subject to annual deductible, then 90% of allowed amount per 36-month period. Amount above the allowed amount is billed to the member.	Subject to annual deductible, then 65% of allowed amount per 36-month period. Amount above the allowed amount is billed to the member.

CareFirst BlueChoice Advantage Medical Supplies Overview		
Service	In-Network	Out-of-Network All services must be authorized
Contraceptive Devices	Covered in full. Depo-Provera, Norplant, intra- uterine devices and any medically necessary insertion, removal, or examination associated with the use of any contraceptive drug or device approved by the FDA for use as a contraceptive.	Subject to annual deductible, then 75% of allowed benefit. Depo-Provera, Norplant, intra- uterine devices and any medically necessary insertion, removal, or examination associated with the use of any contraceptive drug or device approved by the FDA for use as a contraceptive.

Blood, blood plasma, and blood products are covered. Donor processing fees are covered when fees are for participant-directed donations.

Surgically implanted prosthetic devices are covered in full if authorized by CareFirst. Orthopedic and other prosthetic devices are covered when authorized by your in-network Primary Care Provider as well as out-of-network.

Non-Hospital Care

The plan covers home health care, hospice care, and skilled nursing facilities. This section describes the covered expenses for services under the CareFirst BlueChoice Advantage plan.

CareFirst BlueChoice Advantage Non-Hospital Care Overview		
Service	In-Network	Out-of-Network All services must be authorized
Home Health Care	90% coverage . Subject to deductible.	65% of plan allowance, after you have met the annual deductible.
Hospice Care	90% coverage. Subject to deductible. Inpatient benefits are limited to a maximum of sixty (60) days per lifetime. Inpatient benefits are limited to a maximum of 60 days per Hospice Eligibility Additional “reserve” benefits (up to 45 days) apply if the Member exceeds the Hospice Eligibility Period limit Available during last 6 months of life. Other limitations apply	65% of plan allowance, after you have met the annual deductible. Limit of 180 days per lifetime, 60 of which may be used for inpatient hospice care. 45 lifetime reserve days are also available for inpatient or home care. Available during last 6 months of life. Other limitations apply.
Skilled Nursing Facility	90% coverage when authorized by plan. Subject to deductible.	65% of plan allowance – after you’ve met the annual deductible.

Home Health Care

Home health care may provide an alternative to a prolonged hospital stay if your condition allows you to be discharged from the hospital and complete your recovery at home.

You are eligible for home health care benefits if:

- your condition would require hospitalization if home health care benefits were not available; and
- your attending physician submits an approved home health care treatment plan; and
- you are billed by a qualified home health care agency.

To qualify for full coverage in-network, your home health care program must be authorized by CareFirst and begin within seven days of your discharge from the hospital. Otherwise, your benefits will be provided out-of-network.

The plan covers the following home health care expenses when billed by a qualified home health care agency:

- physician's visits (unlimited);
- nursing services (part-time intermittent extended care only);
- physical, occupational, respiratory, speech, and audiological therapy;
- home health aide (if incidental to extended care), and homemaker services (for patient only);
- medical and surgical supplies provided during a visit;
- prescription drugs billed by the home health care agency;
- rental of durable medical equipment; and
- ambulance service between home and hospital.

Private duty nursing services performed by a registered nurse or licensed practical nurse may be covered out-of-network only for up to 50 visits per calendar year (maximum: two hours per day), provided that:

- the nurse is not your relative or residing in your household; and
- your condition requires private duty nursing; and
- your care is ordered by a physician and is consistent with your illness or injury.

Hospice Care

A hospice is designed to provide supportive care for terminally ill patients and their families during the last six months of life. To be eligible for hospice care benefits, a patient must have a confirmed diagnosis of terminal illness.

The plan covers the following services when billed by a hospice:

- all covered inpatient and outpatient hospice services (treatment must be under a physician's direction);
- nursing and home health aide services;
- physical, respiratory, speech, and occupational therapy;
- nutrition guidance by a registered dietitian;
- drugs and medicines (during a covered hospice stay);
- outpatient radiation therapy and chemotherapy;

- [counseling services](#), including family counseling;
- [family bereavement counseling](#) within 90 days of the patient’s death.

Skilled Nursing Facility

A skilled nursing facility provides inpatient care under a doctor’s supervision for patients who are recovering from serious illness or injury but may not need hospitalization.

You are eligible for benefits only if your condition would require hospitalization if the skilled nursing facility benefits were not available. These benefits must be received from an approved facility. To qualify for full coverage, the skilled nursing facility must be authorized by CareFirst. In- and out-of-network benefits cover unlimited days in a skilled nursing facility.

The plan covers the following benefits for any one confinement in an approved skilled nursing facility:

- semi-private room and board;
- nursing care under the supervision of a registered nurse;
- injections, intravenous solutions, dressings, and casts;
- prescription drugs which represent a cost to the facility;
- physical, speech, and occupational therapy furnished by the facility; and
- blood administration and sera (except blood and blood plasma).

Mental Health Care

The plan covers inpatient and outpatient services received in connection with mental health conditions. All inpatient and outpatient treatment for mental health conditions is subject to [pre-certification](#). If you do not obtain a preadmission and admission review by CareFirst before hospital admission for out-of-network benefits, your benefits may be reduced by 50 percent.

The following chart summarizes mental health care benefits under the CareFirst BlueChoice Advantage plan:

CareFirst BlueChoice Advantage Mental Health Care Overview		
Service	In-Network	Out-of-Network All services must be authorized
Inpatient Mental Health Care	90% after \$250 copayment for short term, acute mental health conditions. Subject to deductible.	65% of plan allowance – after you have the annual deductible.
Outpatient Mental Health Care	100% coverage – after \$20 per visit copayment. Subject to deductible. Includes psychotherapy for gender identity disorder.	65% of plan allowance – after you have met the annual deductible for therapy rendered by psychiatrist, licensed psychologist, or licensed clinical social worker. Includes psychotherapy for gender identity disorders.

CareFirst BlueChoice Advantage Mental Health Care Overview		
Service	In-Network	Out-of-Network All services must be authorized
Psychological Testing	<p>Primary Care Provider: \$20 copayment per visit, subject to annual deductible, then 100% of allowed benefit.</p> <p>Specialist: \$40 copayment per visit, subject to annual deductible, then 100% of allowed benefit coverage for psychological and neuropsychological testing is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes. Services include evaluation, diagnosis and treatment of acute and non-acute conditions. The benefits for neuropsychological testing are not counted toward any outpatient mental health and substance abuse visit benefit.</p>	<p>65% of plan allowance – after you have met the annual deductible.</p> <p>Coverage for psychological and neuropsychological testing is provided for outpatient services to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse including psychological and neuropsychological testing for psychological diagnostic purposes. Services include evaluation, diagnosis and treatment of acute and non-acute conditions. The benefits for neuropsychological testing are not counted toward any outpatient mental health and substance abuse visit benefit.</p>

Substance Abuse Treatment

The following chart summarizes plan benefits for inpatient or outpatient treatment of substance (alcohol or drug) abuse. All hospital admissions for substance abuse treatment are subject to pre-certification under the [Utilization Management](#) program.

CareFirst BlueChoice Advantage Substance Abuse Treatment Overview		
Covered Service	In-Network	Out-of-Network All services must be authorized
Inpatient Alcohol/ Substance Abuse	<p>Detoxification: 90% coverage after \$250 copayment. Subject to deductible.</p> <p>Rehabilitation: 90% coverage after \$250 copayment. Subject to deductible. Coverage for up to 30 days.</p> <p>Note: All detoxification and rehabilitation benefits count against the mental health day/visit maximums.</p>	<p>Detoxification: 65% of plan allowance after you have met the annual deductible. Limited to 30 visits per calendar year.</p> <p>Rehabilitation: 65% of plan allowance after you have met the annual deductible.</p>

CareFirst BlueChoice Advantage Substance Abuse Treatment Overview		
Covered Service	In-Network	Out-of-Network All services must be authorized
Outpatient Alcohol/ Substance Abuse	Physician expenses: 100% coverage – after \$20 per visit copayment. Subject to deductible.	Physician expenses: 65% of plan allowance after you have met the annual deductible. Limited to 30 visits per calendar year. Outpatient facility: 65% of plan allowance after you have met the annual deductible.

CareFirst BlueChoice Advantage Dental Discount Plan

Under our medical plan, you receive discounts on dental care from the CareFirst BlueChoice Advantage Discount Dental program. The plan provides discounted benefits for a limited number of dental care services, provided that these services are performed by participating dentists. These discounts are not a separate stand-alone dental plan but are part of your medical coverage if you elect CareFirst BlueChoice Advantage. For more details, please go to www.carefirst.com.

The plan provides allowances for the following services performed by participating dentists:

- routine exams and fluoride treatments;
- pulp vitality tests;
- diagnostic casts;
- cleanings (every six months); and
- oral hygiene instruction.

Discounted benefits are provided for other covered dental services, performed by participating dentists, including:

- x-ray services;
- fillings;
- restorations, crowns, and bridges;
- orthodontics, endodontics and periodontics;
- prosthodontics, removables;
- oral surgery; and
- broken appointment fees.

Vision, Hearing, and Travel Inoculation Services

The plan covers a variety of other health care services, including routine eye and hearing exams.

These services are summarized in the following chart:

CareFirst BlueChoice Advantage Vision, Hearing, and Travel Inoculation Services		
Service	In-Network	Out-of-Network
Routine Eye Exams (limited to one per calendar year)	\$10 when services received from a contracting provider. \$25 at network physician offices. (Referral from Primary Care Provider required).	Not covered. \$33.00
Eyeglasses and Contact Lenses	Discounts available at participating vision centers. There is an additional cost for contact lens fittings.	Not covered.
Hearing Screening Exams	100% coverage – after \$20 per visit copayment. Subject to deductible.	65% of plan allowance after you have met the annual deductible if exam is required as a result of accidental injury.
Hearing Aids	Subject to annual deductible, then 90% of allowed benefit up to \$2,500 per 36-month period.	Subject to annual deductible, then 75% of allowed benefit up to \$2,500 per 36-month period.
Inoculations (including travel inoculations)	Primary Care Provider \$20 copayment per visit. Subject to annual deductible, then 100% of allowed benefit. Specialist \$40 copayment per visit. Subject to annual deductible, then 100% of allowed benefit.	65% of plan allowance - after you've met the annual deductible.

Alternative Health Care

You can receive coverage for acupuncture and chiropractic care through approved providers. Additionally, you are eligible for discounts on alternative therapies including massage therapy. You are responsible for paying the discounted fee at the time of service. A complete list of participating discounted facilities and services are available through CareFirst at www.carefirst.com.

CareFirst BlueChoice Advantage Acupuncture and Chiropractic Overview		
Service	In-Network	Out-of-Network
Acupuncture	\$40 copayment; subject to deductible; up to 20 visits. Covers acupuncture for pain management and anesthesia. Coverage will be provided when such treatment is rendered by a trained practitioner who is licensed or certified as such	65% of plan allowance – after you've met the annual deductible. No visit limit. Covers acupuncture for pain management and anesthesia. Coverage will be provided when such treatment is rendered by a trained practitioner who is licensed or certified as such

CareFirst BlueChoice Advantage Acupuncture and Chiropractic Overview		
Service	In-Network	Out-of-Network
	by the duly constituted authority in the area in which service is rendered and when acting within the scope of such license or certification; and if the practitioner rendering the acupuncture treatment is not an M.D., such treatment must be under the direct supervision of an M.D.	by the duly constituted authority in the area in which service is rendered and when acting within the scope of such license or certification; and if the practitioner rendering the acupuncture treatment is not an M.D., such treatment must be under the direct supervision of an M.D.
Chiropractic	\$40 copayment; subject to in-network deductible; up to 20 visits.	65% of plan allowance – after you’ve met the annual deductible; no visit limit.

Express Scripts Prescription Drug Benefits

When you enroll in CareFirst BlueChoice Advantage, your coverage automatically includes prescription drug coverage. Prescription drug benefits for participants in the CareFirst BlueChoice Advantage plan are provided through Express Scripts. You will receive a separate identification card for your Express Scripts prescription drug coverage. CareFirst BlueChoice Advantage participants also will qualify for the mail service program option for long-term maintenance drugs.

Three-Tier Prescription Plan

Under this program, all covered prescription drugs fall into one of three tiers. The tiers represent the level of cost that CareFirst BlueChoice Advantage participants pay to have their prescriptions filled:

- Tier One - Generics (lowest cost to you): All generic drugs are on the preferred drug list;
- Tier Two - Preferred brand-name [formulary] drugs (moderate cost to you): These brand drugs are chosen by Express Scripts for their quality, effectiveness, and cost. They are not available as a generic drug, and research indicates them to be as effective as Tier Three drugs. A drug gets on the preferred list based on current medical research and input from an independent committee of doctors and pharmacists. Some Tier Two drugs also require a pre-approval be made by your physician with Express Scripts;
- Tier Three - Non-preferred brand-name [non-formulary] drugs (highest cost to you). These brand drugs are considered non-preferred by Express Scripts because they typically are more expensive than Tier Two, and there is a therapeutic equivalent in Tier One or Two. Additionally, some Tier Three drugs require a pre-approval be made by your physician with Express Scripts.

Prior Authorization

Under the three-tier prescription drug program, there is a prior authorization requirement for some drugs. Physicians are required to call Express Scripts (the pharmacy benefit manager) for prior authorization before they write prescriptions for some drugs and to authorize refills on current prescriptions for some drugs. To determine whether your prescription requires a prior authorization,

you either may call Express Scripts’ customer service at 877-486-5984 or go online at www.express-scripts.com. Without prior authorization, you will pay the full price of the prescription rather than the copayment.

Retail Program

The retail program provides a 34-day or less supply of medication. Present your Express Scripts card at any participating pharmacy and pay the appropriate amount for your medication: \$10 for generic (Tier One), 30 percent coinsurance to a maximum of \$30 for Preferred brand-name (Tier Two), or 50 percent coinsurance to a maximum of \$50 for Non-preferred brand-name (Tier Three).

Mail Service

The mail service prescription drug program is an integrated feature to your pharmacy benefits. Once ordered, your prescription is reviewed and dispensed by a registered pharmacist and is mailed directly to your home. The mail order program can provide up to 90-day supply for only two-and-a-half times your retail program maximum cost: \$25 for Generic (Tier One), 30 percent coinsurance to a maximum of \$75 for Preferred brand-name (Tier Two), or 50 percent coinsurance to a maximum of \$125 for Non-preferred brand-name (Tier Three)

Generic Preferred Physician’s Choice

Under this program with Express Scripts, a substitution with a generic drug is made for mail order and pharmacy prescriptions. When a physician does not indicate that the prescription be “dispensed as written,” either a chemically-equivalent generic drug will be dispensed, or if you still wish to have the brand drug, you will be charged the higher Tier Two or Three brand coinsurance amount plus the difference between the cost of the brand-name drug and generic. If the physician indicates that the prescription is to be “dispensed as written,” then you will be charged the higher Tier Two or Three brand coinsurance.

Express Scripts Prescriptions Overview	
Coverage	Benefit
Prescriptions filled by pharmacy	
Generic	\$10 generic
Brand Name preferred (formulary)	30% coinsurance to \$30 maximum
Brand Name non-preferred (non-formulary)	50% coinsurance to \$50 maximum
Mail order prescriptions – up to 90-day supply	
Generic	\$25 generic
Brand Name preferred (formulary)	30% coinsurance to \$75 maximum
Brand Name non-preferred (non-formulary)	50% coinsurance to \$125 maximum

Express Scripts Prescriptions Overview	
Coverage	Benefit
Excluded Medications	100% Participant Responsibility

Step Therapy

The step therapy program is designed for patients with certain conditions that require them to take medications regularly. In this program, the medication therapy for a medical condition begins with the most cost-effective medication and progresses to other more costly therapy(s), should the initial medication not provide adequate therapeutic benefit.

The program's goal is to help you choose a medication that is proven safe and effective, while getting it at the lowest possible cost. By using the most cost-effective first line medications you will not only save money with lower copayments, but the university and your colleagues save as well, as it helps ensure that they can continue to provide excellent coverage for you and your family.

If it is documented in your prescription drug history that you previously had tried a generic medication and it was not effective, your doctor will be able to request the brand drug.

In step therapy, medications are grouped into categories.

- Step One: First line medications – mostly generic medications proven safe, effective, and affordable. These medications are to be tried first; and
- Step Two: Second line medications – mostly higher costing brand-name medications.

Step therapy is a process to ensure that you receive a cost-effective therapy. You will first try a recognized first-line medication (Step One) before approval of a more costly and complex therapy is approved (Step Two). If the Step One therapy does not provide you with the therapeutic benefit desired, your physician may write a prescription for a second line medication. Generally, second line medications require the usage and failure of a first-line medication before coverage. The step therapy approach to care is a way to provide you with savings without compromising your quality of care.

Certain chronic and non-chronic drug classes are subject to step therapy. For example, step therapy medication classes include cholesterol, acne, antidepressants, acid reflux, and anti-inflammatory. If your physician writes a new prescription for a medication that is part of the step therapy program, and the medication is not already part of your documented prescription drug history, then your physician will need to write you a prescription for a first-line medication. You may request that your pharmacist call the doctor for you to have your physician submit a prior authorization request for your current prescription before you can continue to receive coverage for the medication. A prior authorization is a request to the physician to document why you cannot take a first-line medication and must use a second-line medication. You or your physician can begin the prior authorization process by calling Express Scripts at 877-486-5984.

Excluded Medications

Excluded medications are not covered under the Express Scripts plan. Each of the excluded drugs have 1-5 alternatives covered under the plan that you can discuss with your doctor. If you choose to receive an excluded medication, you will be responsible for the full cost of the prescription. Excluded prescriptions

are also not applicable toward the out-of-pocket maximum.

CuraScript/Accredo

Prescriptions for specialty medications (injectable, oral, and infused medications) for complex health conditions such as cancer, bleeding disorders, and rheumatoid arthritis, are filled by mail order and generally will require a pre-authorization. CuraScript/Accredo, the specialty pharmacy for our program, will ship medications to the location specified (home, doctor's office, or other location). In special situations, CuraScript/Accredo will allow certain medications to be filled through a retail pharmacy filing.

Filing Your Medical Claims

All claims for benefits under the medical plan should be filed with CareFirst within 12 months of the date that the services or supplies were received.

If you use in-network benefits, the plan will pay your provider(s) directly. There are no claim forms to complete when you receive care in-network.

If you use out-of-network benefits and your provider is a participating CareFirst BlueChoice Advantage provider, your provider will submit claims for you and CareFirst will pay your provider directly.

If your provider is not a participant in CareFirst BlueChoice Advantage, you may have to pay your provider directly. You should attach the provider's itemized bill to your completed Health Benefits Claim Form and return the form to CareFirst for reimbursement or file your claim online at www.carefirst.com. If you have any questions about the claim filing procedure, please contact the Benefits Team in the Office of Human Resources.

Denied Claims

If CareFirst denies your claim for plan benefits, you will receive a written notification of the denial. You then may request further information or provide additional information about your claim.

The plan has established and maintained a procedure by which a member or their authorized representative has a reasonable opportunity to appeal an adverse benefit determination to the plan and under which there will be a full and fair review of the claim and the adverse benefit determined. You or your authorized representatives have the right to file an appeal within 180 days from the date of receipt of the written notice of any adverse benefit determination.

You, or your authorized representative or your health care provider acting on your behalf, have the right to request an appeal of this matter to CareFirst BlueCross BlueShield and/or CareFirst BlueChoice, Inc. (collectively CareFirst). Please file your written appeal within 180 days of this date of this notice to the mail administrator address noted below.

CareFirst BCBS Mail Administrator
PO Box 14114
Lexington, KY 40512-4114

Include any additional information that you would like to be considered regarding a claim. CareFirst will respond to you, or your authorized representative, and your health care provider acting on your behalf, within 60 calendar days of receiving an appeal. If they continue to deny the payment or service,

sustain the reduced coverage or service requested, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision.

Exclusions and Limitations

The CareFirst BlueChoice Advantage plan will not pay for certain kinds of treatment or care. The following list of exclusions and limitations is only a summary. You should contact CareFirst customer service at 1-800-628-8549 for more information concerning the plan's exclusions and limitations.

The CareFirst BlueChoice Advantage plan will not pay for:

- services or supplies which are not medically necessary or are experimental or investigational in nature. The criteria for deciding if a service or supply is experimental or investigational are (1) most of the scientific data, such as controlled studies in peer-reviewed journals or literature, does not demonstrate that its use results in a better health outcome for a specific diagnosis, (2) it is not in accord with generally accepted standards of medical practice, or (3) it does not have federal or other required governmental agency approval at the time it is received;
- charges you would not have to pay if you did not have coverage, charges which are eligible for workers' compensation benefits, or charges for care related to a military disability or other condition from war (declared or undeclared);
- charges for non-medical devices or personal comfort items and services;
- services or supplies that are covered under another insurance (i.e., no-fault auto insurance);
- treatment for weight reduction and obesity except for the surgical treatment of morbid obesity;
- any care to the extent that benefits are obtained (or could have been obtained) under Medicare;
- vocational testing and counseling, recreational therapy, educational therapy, self-help training, and other nonmedical self-care, including marriage counseling or parent counseling;
- extended care or private duty nursing, except where covered by the plan;
- cosmetic surgery or other services related primarily to changing or improving appearance, except as provided elsewhere in this plan summary;
- drugs, vitamins, or minerals which do not require a written prescription, or supplies related to birth control (available under prescription drug plan);
- services or supplies related to organ transplant procedures (including complications arising from any such procedure), except where specifically covered by the plan;
- services or supplies related to dental care, except as the result of an accidental injury or oral surgery (determined by CareFirst BlueChoice as medically necessary); and
- any care, services, or devices not specifically listed in the plan document.

Additional In-Network Exclusions

For CareFirst BlueChoice Advantage in-network benefits, all care must be provided or arranged in advance through your Primary Care Provider. It is also important to remember that some services which are not covered in-network may be covered out-of-network.

CareFirst BlueChoice Advantage in-network benefits will not cover:

- reversal of vasectomies or tubal ligations;

- durable medical equipment, corrective appliances, or prosthetic devices, in excess of the maximum benefit;
- outpatient private duty nursing;
- routine podiatric care;
- take-home drugs or other self-administered medications;
- treatment of the temporomandibular joint (TMJ) disorder;
- long-term rehabilitation or physical therapy;
- services which primarily are for custodial care (custodial care is care which does not require the continued attention of trained medical personnel; services are considered custodial when they can be learned by an average individual who does not have medical training);
- hospitalization primarily for physical therapy, or occupational therapy, unless therapy cannot be given on an out-patient basis and the complexity of the patient's condition requires additional skilled care; and
- certain transgender-related procedures.

Additional Out-of-Network Exclusions

CareFirst BlueChoice Advantage out-of-network benefits will not cover:

- skilled nursing facility admissions or care in a hospital or rehabilitation facility when the stay is for custodial care, convalescent care, rest, or rehabilitation;
- annual or routine physicals, unless provided for by the plan;
- treatment for sexual dysfunction, inadequacy, or impairment;
- eye refractions or eyeglasses unless required due to accidental injury;
- temporal mandibular joint (TMJ) treatment, except for services or procedures related to surgical procedures for the excision or reduction of the TMJ;
- rental or purchase of deluxe medical equipment or the purchase of orthopedic shoes, services, or appliances if not permanently fastened to an orthopedic brace;
- services or supplies provided by a provider who is the patient's spouse, parent, sibling, or child; and
- services or supplies for the medical treatment of nearsightedness or farsightedness, including radial keratotomy.

Coordination of Benefits

In many families, more than one family member works, and it is possible for the same individual to be covered by more than one health care plan.

If you or your eligible dependents also are covered by another plan or plans providing health care benefits, payments from the plans will be coordinated so as not to exceed the total of allowable expenses. In other words, all plans combined will not pay more than 100 percent of the actual cost of the services and supplies provided.

When two plans are involved, one plan will pay the claim first (the primary plan) and the other plan (the secondary plan) will pay up to the difference between the amount that the primary plan pays and the total covered expenses.

The following rules apply when coordinating benefits. The CareFirst BlueChoice Advantage plan is

primary for covered expenses that you incur:

- if your spouse works, and is covered by their employer's health care plan, that plan is primary for your spouse's health care expenses;
- if your dependent child is covered by your plan and your spouse's plan, the primary plan is the plan of the parent whose birthday occurs earlier in the year;
- if you are divorced or separated, the plan of the parent with custody is primary, unless the court decree states otherwise;
- in the case of dependent children after divorce, if you remarry and have custody, the CareFirst BlueChoice Advantage plan will be primary, followed by your current spouse's plan and then your former spouse's plan; and
- when none of the above rules for coordinating benefits can be applied, the benefits of the plan which covered the participant the longest pays first.

If you have any questions about the coordination of benefits rules, please contact CareFirst.

Subrogation

If you are injured due to someone else's negligence or wrong-doing, the CareFirst BlueChoice Advantage plan has the legal right to recover benefit payments for medical care related to your injury. This right is known as "subrogation."

No-Fault Insurance

If you or a member of your family is in an auto accident which is covered under a state or federal no-fault auto insurance law, your CareFirst BlueChoice Advantage plan will not duplicate medical benefits payable by a no-fault insurance carrier.

If you are involved in an accident that is covered by no-fault insurance, you first must claim benefits for medical expenses from the motor vehicle insurer. The CareFirst BlueChoice Advantage plan may help to pay for additional covered expenses.

2.6 Kaiser Permanente

Kaiser Permanente is an HMO which is designed to provide you and your family with a full range of health care services on a pre-paid basis. There are conveniently located Kaiser Permanente medical centers throughout the Washington, DC and Baltimore metropolitan areas.

When you first join Kaiser Permanente, you will select a Primary Care Physician and Home Center that is most convenient for you. You then can use your Home Center or any other center in the Kaiser Permanente system.

Non-Emergency Care

If you join Kaiser Permanente, all of your non-emergency care will be provided through Kaiser Permanente's staff doctors, medical centers, or affiliated hospitals. All of the following non-emergency services are paid in full by Kaiser Permanente after a \$20 per visit copayment for office visits to your primary physician, \$40 to a specialist, and \$250 per admission copayment for hospital admissions:

- in-patient hospital care;
- doctors’ office visits;
- doctors’ bills for surgery;
- home health care;
- x-ray and lab tests; and
- hospice care.

The plan also provides coverage for acupuncture, chiropractic, hearing aids, and infertility.

There are no copayments for wellness physical exams and screenings for adults and children over the age of five for care such as: routine physicals and PSA test, well child exams, annual OB/GYN exams, mammograms, screenings and PAP smears, routine immunizations, and prostate and colorectal cancer screenings. Children under five receive 100 percent coverage for all Primary Care Physician office visits, including well baby care visits (specialist office visits are subject to a copayment).

Benefits for prescription drugs are paid fully after a copayment by you. This copayment will be lower if you use a Kaiser Health Center pharmacy or mail order. Prescriptions also may be filled at other participating pharmacies.

Mental Health Care

Kaiser Permanente provides fully paid benefits for inpatient mental health care. There are no limits on the number of outpatient mental health care visits.

Benefits for outpatient visits are paid fully after a \$10 copayment for group sessions and a \$20 copayment for individual sessions. Kaiser Permanente also provides 100 percent coverage of medication, evaluation, and maintenance visits.

Emergency Care

In a life-threatening emergency, Kaiser Permanente members can go to any hospital or emergency facility. A 24-hour emergency line also is available to members for non-life threatening situations at 1-800-677-1112. You must contact Kaiser within 48 hours of having been treated for a life-threatening emergency in order to have the treatment covered.

Prescription Drug Benefits

The following table contains the copayment structure for the three-tier prescription drug program.

Kaiser Prescriptions Overview	
Coverage	Benefit
Prescriptions filled in a Kaiser center (30-day supply)	
Generic	\$10
Brand Name preferred (formulary)	\$20
Brand Name non-preferred (non-formulary)	\$35
Prescriptions filled by an outside pharmacy (30-day supply)	

Kaiser Prescriptions Overview	
Coverage	Benefit
Generic	\$20
Brand Name preferred (formulary)	\$40
Brand Name non-preferred (non-formulary)	\$55
Mail order prescriptions (60-day supply)	
Generic	\$16
Brand Name preferred (formulary)	\$36
Brand Name non-preferred (non-formulary)	\$66

Kaiser Discount Dental Care

Under Kaiser’s medical plan, you receive a discount on dental care for more than 250 dental procedures. These discounts are not provided under a separate stand-alone dental plan, but are a part of your medical coverage if you elected Kaiser Permanente. For details and dentist network information, please go to www.kaiserpermanente.org or www.dominiondental.com/kaiserdentists.

The plan provides allowances for the following services performed by participating dentists:

- routine cleanings (once per six months);
- oral examinations (once per six months);
- bitewing X-rays; and
- topical fluoride.

Kaiser Discount Vision

The following vision care benefits are provided through Kaiser health centers:

- 100 percent coverage for routine eye exams after \$20 per visit copayment (\$40 for an ophthalmologist). Limited to one per calendar year;
- discount on eyeglasses when purchased through Kaiser Permanente; and
- discount on initial fitting and purchase of contact lenses. For more information, visit www.kaiserpermanente.org.

Alternative Health Care Options

Kaiser members can receive coverage for acupuncture and chiropractic care through Kaiser- approved providers, as well as discounts on alternative therapies including massage therapy. Kaiser members are responsible for paying the discounted fee at the time of service. A complete list of participating discounted facilities and services are available through Kaiser Permanente.

Kaiser Acupuncture and Chiropractic Overview	
Acupuncture	\$40 copayment, up to 20 visits
Chiropractic	\$40 copayment, up to 20 visits

2.7 Additional Important Information

This section contains additional important information about your health care benefits, including:

- coverage after age 65;
- when your coverage ends;
- continuation of health care coverage;
- retiree coverage.

Coverage after Age 65

If you remain in active employment with the university after age 65, your university-sponsored medical care coverage will continue for you and your eligible dependents, unless you elect otherwise. This coverage coordinates with Medicare while you are in active employment as follows:

- the university-sponsored medical plan will be the primary provider to which you submit your medical claims first; and
- Medicare will be the secondary provider to which you submit your claims for payment on the unpaid balance.

You may elect to have Medicare as your primary provider for you or your spouse age 65 or older. If you choose to make Medicare the primary provider, your university-sponsored medical benefits will end, and your medical coverage (and that of your spouse if over age 65) will be provided entirely through Medicare.

If you are enrolled in a university health plan at the time of your retirement and meet age and service requirements, you may be eligible to continue your coverage when you retire. As a retiree, your coverage will coordinate with Medicare. Please see the [Benefits Extension Plan](#) and [Becoming Eligible for Medicare](#) for more information.

When Your Coverage Ends

Your university-sponsored medical care coverage will end on:

- the last day of the month in which you terminate full-time employment with the university;
- the date that your employment classification changes to a classification that is not covered by the plan;
- the date that a specific university-sponsored medical plan is discontinued if it is the only medical coverage that you are receiving; and
- the date that the university's benefit program is terminated.

Medical plan coverage for a dependent will end when they no longer meets the definition of "[eligible dependent](#)."

Continuation of Health Care Coverage

If university-sponsored medical, dental, or health care flexible spending account coverage for you or an eligible dependent ends for one of the reasons discussed in this section, you may arrange to continue this coverage at your own expense. You may be eligible to participate in the [Benefits Extension Plan](#) which extends optional participation in the university's group health care plans if you meet certain

combinations of age and full-time service. Special rules that apply to this benefit. This continuation is provided under the terms of COBRA (the Consolidated Omnibus Budget Reconciliation Act).

Under COBRA, your coverage may be continued only under the following conditions:

- you or the other covered person (if applicable) must meet the notice and election requirements outlined in this section; and
- you or the other covered person (if applicable) must pay the entire plan premium (equal to 102 percent of the cost of plan coverage). This premium includes the amount that the university would otherwise have paid on your behalf; and The continued coverage will end as of:
- the date that you or an *eligible dependent becomes entitled to Medicare or covered under another group health plan*; or
- the date that the continuation period expires; or
- the date that you fail to make any required contributions; or
- the date that the applicable university-sponsored health care plan is discontinued.

In the case of extended coverage due to disability, the continued coverage also will end if you or the other covered person (if applicable) are determined to be no longer disabled.

A special rule applies if you or an eligible dependent becomes covered under another group health plan and that plan contains a *pre-existing condition limitation or exclusion* that affects you or the eligible dependent.

Termination of Employment

If you terminate employment for any reason (other than gross misconduct), you and your eligible dependents may elect to receive up to 18 months of continued health care coverage, provided that you or the other covered person (if applicable) pays the entire premium for this coverage.

You or an eligible dependent may receive up to an additional 11 months of continued health care coverage (for a total of 29 months of coverage) if you or your eligible dependent is disabled at the time your termination of employment occurs. This 11-month extension will apply only for the disabled person and only if:

- you or the other covered person (if they are disabled) apply for and receive a disability determination from Social Security; and
- you notify the Benefits Team in the Office of Human Resources within 60 days of receiving the disability determination (and before the end of the initial 18-month continuation period); and
- during the 11-month extension period, you pay an amount equal to 150 percent of the applicable plan premium.

The disability extension also will apply if your plan participation ends due to layoff or a reduction in work hours.

The disability extension period will end under any of the circumstances listed in the *Layoff or Reduction in Work Hours* section. However, a special rule applies if you receive a determination from Social Security that you (or the other covered person, if applicable) are no longer disabled. In this case, the disability extension period will end 30 days after the date that you receive this determination (or on the first day of the month following the date that the 30-day period ends, if later.)

Termination of Dependent Coverage

If a dependent child's medical care benefits end because that child no longer meets the definition of "*eligible dependent*," health care coverage may be continued for up to 36 months – provided that you or the covered person pays the entire premium for this coverage.

Layoff or Reduction in Work Hours

If your participation ends due to a layoff or reduction in your work hours, you and your eligible dependents may elect to continue health care coverage for up to 18 months after your participation ends. You or the other covered person (if applicable) must pay the entire premium for this coverage.

You or an eligible dependent may be eligible for extended continuation coverage if you or your dependent is disabled at the time your layoff or reduction in work hours occurs. See [Termination of Employment](#) for more information.

Entitlement to Medicare

Eligibility for continuation coverage ends when the covered person becomes entitled to Medicare. However, if your continuation coverage ends due to your becoming entitled to Medicare, your eligible dependents may elect to continue their health care coverage for up to 36 months (measured from the date of the original qualifying event) – provided that you or the covered person pays the entire premium for this coverage. If you work for the university after age 65 and elect Medicare as your primary provider (see Coverage after Age 65), your eligible dependents may elect to continue their health care coverage for up to 36 months. You or the covered person must pay the entire premium for this coverage.

Death Benefits

If your death occurs while you are actively employed, your eligible dependents may elect to continue their health care coverage for up to 36 months. They may do so by paying the entire premium for this coverage.

Divorce or Legal Separation

If you become divorced or legally separated, your spouse (or former spouse, if applicable) may receive up to 36 months of continued health care coverage, provided that you or your spouse (or former spouse, if applicable) pays the entire premium for this coverage.

Coverage for eligible dependent children who lose their health care coverage due to your divorce or legal separation also may be continued for up to 36 months. The party responsible for payment of the applicable premium may be determined by a court decree or other legal settlement.

If an eligible dependent child becomes covered under another group health plan, continuation benefits for that child will end unless the dependent child is affected by a [pre-existing condition](#).

Qualified Medical Child Support Orders

Participants and beneficiaries may obtain a description of the plan's procedures governing qualified medical child support order (QMCSO) determinations. A copy of the procedures may be obtained, without charge, from the Benefits Team in the Office of Human Resources.

Pre-existing Conditions

Continuation coverage for you or another covered person ends when you or the other covered person becomes covered under another group health plan. However, a special rule applies if you or another covered person becomes covered under another group health plan and that plan contains a pre-existing condition limitation or exclusion that affects you or the other covered person. In this case, the affected person's medical plan coverage may be continued until the date that it otherwise would have ended, provided that:

- the pre-existing condition limitation affects you or the other covered person; and
- the pre-existing condition is covered under your university-sponsored health care plan; and
- you or the other covered person (if applicable) continues to pay the entire premium for continued coverage.

If the above conditions are met, your university-sponsored health care plan will be the primary provider for the pre-existing condition only and the secondary provider for all other services covered by the plan.

Notification and Election Period

You or an eligible dependent (if applicable) will receive a written notice of the right to elect continued health care coverage if:

- you terminate employment; or
- you are affected by a layoff or reduction in work hours; or
- your death occurs during active employment; or
- you become entitled to Medicare.

It is your responsibility to notify human resources concerning a divorce, legal separation, eligibility for a disability extension, or loss of a dependent child's eligibility status under your university-sponsored health care plan. This notification should be provided to human resources within 60 days of the date that the qualifying event (e.g., divorce) occurs. You or the other covered person (if applicable) then will receive a written notice of the right to elect continued health care coverage.

If your university-sponsored health care coverage ends for one of the above reasons, you may elect to continue your coverage by contacting the Benefits Team in the Office of Human Resources within 60 days of the date that your coverage otherwise would have ended (or within 60 days of the date you receive notification of your right to elect continued coverage, if later).

If you (or the other covered person, if applicable) do not choose to continue coverage within the 60-day election period, the right to elect continued health care coverage will end.

2.8 Benefits Extension Plan

Medical care benefits may be continued for eligible faculty and staff members who retire from active employment with the university. You should contact the Benefits Team in the Office of Human Resources concerning medical benefits for eligible retired faculty and staff members.

Benefits Extension Plan

You may be eligible to participate in the Benefits Extension Plan (BEP) which extends optional participation in the university's group health care plans until you become eligible for Medicare, if you meet certain combinations (described below) of age and full-time service. If you wish to continue one of these plans, you should consult with the Benefits Team in the Office of Human Resources to discuss the options available before your retirement becomes effective. It is not possible to renew these benefits at a later time if they are allowed to lapse.

The benefits available to you are provided in two different sections below, depending on your date of hire and date of retirement. The two sections are as follows:

- faculty and staff members hired on or after January 1, 1993; and
- faculty and staff members hired before January 1, 1993, and retiring on or after May 1, 1993.

Each of the sections provides a different calculation of BEP benefits and matrix of age and service requirements. The university reserves the right to amend the Benefits Extension Plan.

Faculty and Staff Members Hired On or After January 1, 1993

If you were hired on or after January 1, 1993, you are eligible to participate in a university group health plan upon your retirement at age fifty-five (55) or later, until you become eligible for Medicare. The full cost of the plan coverage will be at your sole expense. Your spouse and dependents likewise may participate in the group health plan at your sole expense.

To participate in BEP, you must have elected a university group plan prior to retirement, and that election must have been in effect at the time of your retirement from active service. If no university group health plan is in effect at retirement, you cannot enroll in BEP. As a participant in the BEP benefit program, you are eligible for annual open enrollment provisions, and, if you so desire, may change from one university health plan to another during the annual open enrollment period. If your family status changes after enrolling in the BEP plan upon retirement (e.g., by marriage or the birth of a dependent), you may add your spouse and/or dependent coverage within thirty (30) days of such change or during any subsequent open enrollment period. All such coverage for your spouse and dependents will be at your own expense.

If you maintain coverage in a university group health plan under the BEP plan, you will have the option to maintain coverage in the university group dental plan at your own expense.

If you retire from the university on disability (as defined by the university's insurance company or Social Security), you are eligible to participate in the university group health plan under the same terms and conditions as set forth in this section.

Faculty and Staff Members Hired Before January 1, 1993 and Retiring On or After May 1, 1993

If you were hired before January 1, 1993 and retiring on or after May 1, 1993, at age 55 or above, you are eligible for BEP benefits under the years-of-service matrix set forth below in Table A. The amount of monthly BEP contribution the university will pay toward the cost of your participation in a university group health plan or Medicare Exchange is determined by multiplying the applicable percentage from the matrix in Table A by the applicable university contribution in Table B.

The amount of monthly BEP contribution will in no case exceed the actual cost of your individual coverage. You are responsible for paying the portion of your health plan premium that exceeds the BEP contribution. If you qualify under this provision of the benefit program, you can continue coverage for spouse and dependents at your own expense.

The BEP age and service requirements are as follows:

- you must be at least fifty-five (55) years of age at time of retirement; and you must meet the service requirements listed below in Table A.

Benefits Extension Plan Age and Service Requirements Table A	
Completed Years of Service	Percentage of University Contribution
Less than 15	0%
15	50%
16	55%
17	60%
18	65%
19	70%
20	75%
21	80%
22	85%
23	90%
24	95%
25	100%
26	110%
27	120%
28	130%
29	140%
30 and over	150%

Benefits Extension Plan Age and Service Requirements Table B	
Year	Contribution per Retiree
1999 and beyond	\$180/month

To participate in BEP, you must have elected a university group plan prior to retirement, and that election must have been in effect at the time of your retirement from active service. If no university group health plan is in effect at the time of your retirement, you cannot enroll in BEP. As a BEP participant you are eligible for open enrollment provisions, and may, if so desired, change from one university plan to another during the annual open enrollment period. If your family status changes after your retirement (e.g., by marriage or the birth of a dependent), you may add spousal and/or dependent coverage within thirty (30) days of such change or during any subsequent open enrollment period. All

such coverage for your spouse and dependents shall be at your own expense.

If you qualify under this section of the benefit program, and maintain your group health plan you will have the option to maintain coverage in the university group dental plan at your own expense.

If you retire on disability (as defined by the university's insurance company and Social Security), you will receive BEP benefits under the same terms and conditions as set forth in this section, except that (1) the age requirement is waived; and (2) if you have less than 25 years of service at the university, the benefit will be computed as if you had 25 full years of service.

The Plan Administration section contains additional important information about your medical care benefits, including your rights as a participant under ERISA (the Employee Retirement Income Security Act).

Becoming Eligible for Medicare

When you turn age 65, you become eligible to enroll in Medicare Parts A and B. At that time, the American University BEP medical, prescription and dental insurance ends and Medicare Parts A and B become your primary insurance. You must enroll in Medicare Supplemental and Part D prescription insurance or a Medicare Advantage Plan through a Medicare Exchange provided by Mercer Marketplace 365+ Retiree.

You are encouraged to call Mercer Marketplace 365+ Retiree at (855) 871-0436 and speak with a Mercer benefits counselor at least three months before your 65th birthday to ensure that you continue to have comprehensive health coverage when you become eligible for Medicare. Through Mercer Marketplace 365+ Retiree you may also enroll in dental and vision coverage.

Health Reimbursement Arrangement (HRA) account

If you are eligible for a subsidy from the university towards the cost of your health coverage, the subsidy will be available to you via a Health Reimbursement Arrangement (HRA) account administered by Mercer Marketplace 365+ Retiree.

You may request reimbursement of eligible expenses, including:

- Medical, dental and vision insurance purchased through Mercer
- Medicare Part B and Part D premiums, as well as Income-Related Monthly Adjustments (IRMAA) for Parts B and D
- Out-of-pocket expenses other than insurance premiums (see IRS Code Section 213(d) IRS Publication 502)

You may choose from three types of reimbursement options for eligible healthcare expenses and you may receive your reimbursement via check or direct deposit:

- Automatic Premium Reimbursement
- Recurring Premium Reimbursement
- One-Time Reimbursement

Visit the [Benefits Extension Plan webpage](#) for more information.

Special Note for Dependents Under Age 65

If you have an eligible dependent who is under age 65, they will need to remain with the current American University BEP medical, prescription, and/or dental plan, subject to the eligibility requirements of the plan until they reach age 65. This is separate from any insurance coverage that you may obtain through Mercer Marketplace 365+ Retiree.

Upon reaching age 65, your dependent is invited to select from the health care, prescription, and/or dental options available through Mercer Marketplace 365+ Retiree.

If you have an eligible dependent child who is under age 26, they can be covered under the American University medical, prescription, and/or dental plan for active employees, subject to the eligibility requirements of the plan, until they reach age 26. When your dependent child turns age 26, they will be covered through the end of the year they turn age 26 and will then become eligible to continue coverage through COBRA for up to 36 months.

3.0 Dental Benefits

3.1 Introduction

Dental care is an important part of your family's total health care program. Eligible faculty and staff members of American University may elect one of two separate stand-alone dental plans offered by Delta Dental, regardless of whether they enroll in the medical plans. The dental plans supplement and expand the limited number of dental services that may be covered by the medical plans. The dental plan options include the Basic plan with one tier of provider participation, and the Comprehensive plan, a PPO (Preferred Provider Organization) with three tiers of provider participation.

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided, the eligibility rules, or any other feature of the plan. Your participation in the university's benefit program does not guarantee your employment with the university for any length of time.

3.2 Dental Plan Eligibility and Participation

The highlights of the university's dental benefits include:

- basic plan with one tier of provider participation with coverage for diagnostic, preventive, and some basic and restorative services;
- comprehensive PPO (Preferred Provider Organization) with three tiers of provider participation with a wide range of covered services for preventive, basic, and major dental care;
- coverage for your eligible dependents;
- a pre-tax contribution option; and
- the flexibility to change your dental plan election at least once each year.

Eligibility

You are eligible to participate in the dental benefit program if you are:

- a full-time faculty member; or
- a regular, full-time staff member.

Full-Time Faculty Member

You are considered to be a full-time faculty member if:

- you currently have a contract as a full-time faculty member and receive remuneration; or
- you have a nine-month contract, receive remuneration, and have been appointed for the upcoming fall semester.

Regular, Full Time Staff Member

You are considered to be a regular, full-time staff member if:

- your position is classified as full-time; and
- you are scheduled to work for at least 28 hours per week.

You are not eligible for participation in the dental benefit program if you work on a part-time or

temporary basis. If you are not certain about your eligibility for participation, please contact the Benefits Team in the Office of Human Resources.

Coverage for Your Eligible Dependents

In addition to covering yourself, you may elect to cover your eligible dependents. Your eligible dependents are:

- your spouse, opposite- or same-sex domestic partner (for plan purposes, the term spouse extends to both opposite- and same-sex domestic partners);
- your dependent children up to the last day of the year in which they reach age 26; or
- your unmarried dependent children over age 26 who are incapable of supporting themselves due to a mental or physical disability (provided that this disability to the Benefits Team in the Office of Human Resources occurred before the date that the child reached age 26).

You must provide the appropriate certification of disability in order to qualify for the extension of a dependent child's eligibility beyond age 26.

Adopted or Foster Children

For plan purposes, the term "children" includes the children of either parent, adopted children, or children who are in the process of being adopted. The term "children" also includes children who are your financial responsibility and for whom you or your spouse have been appointed legal guardian.

Spouse

For plan purposes, the term "spouse" refers to the legal spouse of the employee.

Domestic Partner

For plan purposes, "domestic partners" refers to persons of the opposite or same gender who: have a completed and document-supported [Domestic Partner Affidavit](#) on file with human resources and:

- are registered as each other's domestic partner, civil union partner, or reciprocal beneficiary with a government agency where such registration is available; or
- can certify that they:
- both are at least 18 years of age and mentally competent to consent to a legally binding contract;
- are each other's sole domestic partner and intend to remain in this relationship indefinitely;
- share a close, personal relationship and are responsible for each other's common welfare;
- share the same primary residence (and have shared this residence for the past twelve months) and intend to do so indefinitely;
- are not married to anyone of the same or opposite sex nor have had another domestic partner within the past twelve (12) months; are not related by blood closer than would bar marriage in the District of Columbia or the state they live in;
- are financially interdependent on each other; and
- are able to demonstrate their joint responsibility to each other's common welfare and financial interdependence for a minimum of 12 months preceding the submission of the [Domestic Partner Affidavit](#).

Coverage Levels

You may choose one of the following levels of coverage for dental benefits:

- individual; or
- individual plus one coverage; or
- family coverage.

Cost

The university subsidizes part of the cost for your dental coverage. Your cost will depend on the level of coverage you choose. You may elect to pay for your dental coverage with:

- pre-tax contributions; or
- after-tax contributions.

Electing the pre-tax contribution option will give you an advantage because these contributions come out of your pay before federal, Social Security, and (in most cases) state and local taxes are applied. Since your pre-tax contributions are not included as income on your W-2 earnings statement, they will reduce your taxable income.

Your pre-tax contributions for a given year may reduce your Social Security wage base for that year. This may result in a slight reduction in your Social Security benefits when you retire.

After-Tax Contributions

You may elect to make after-tax contributions towards the cost of your dental coverage. Since these contributions will come out of your pay after taxes are applied, they will not reduce your taxable income.

A special rule applies if you elect to pay for your coverage with after-tax contributions. In this case, you may reduce your level of coverage at any time. However, you will not be permitted to increase your level of coverage during the year, unless you have a [*qualifying family status change*](#).

For example, suppose that you elect to pay for individual plus one coverage with after-tax contributions. You may change this election to cover only yourself at any time during the year. Once you make this change, you will not be permitted to elect individual plus one or family coverage for the balance of the calendar year unless you have a qualifying change in your family status.

The taxation of domestic partner benefits is complex. Please contact the Benefits Team in the Office of Human Resources for help in determining the availability of pre-tax dental benefits.

How to Enroll

In the fall of each year, the university sponsors an annual open enrollment period, during which you can:

- add or drop the dental plan;
- change your level of coverage (for example, from individual to family coverage);
- add or remove dependents from your coverage; or
- not elect coverage.

If you elect to make pre-tax contributions, the choices you make during the annual open enrollment period will remain in effect for the next calendar year, unless you have a [*change in family status*](#).

If you do not make a change before the end of the applicable open enrollment period, your current dental plan election will stay in effect for the next calendar year. You may not make a new election until the next annual open enrollment period unless you have a [*change in family status*](#).

New Faculty or Staff Members

[*New faculty or staff members who are eligible to participate*](#) may enroll for dental coverage during their first 30 days of full-time employment with the university. This coverage will become effective on the first day of the month following your date of hire. If your date of hire is the first day of the month, your coverage will be effective on that day.

For example, assume that you begin work on August 18 of a given year. Your dental coverage will begin on September 1, provided that you enroll on a timely basis.

If you do not enroll within 30 days of your date of hire, you will not be eligible for dental coverage for the remainder of the calendar year. You may not make a dental coverage election until the next annual open enrollment period, unless you have a [*qualifying change in your family status*](#) (see the following section).

Changing Coverage during the Year: Open Enrollment and Qualifying Events

If you elect to pay for your coverage with pre-tax contributions, the coverage level you elect during the open enrollment period will remain in effect during the next calendar year. You can change this election during the year only if your family status changes. Changes in family status include:

- marriage, divorce, or legal separation;
- 12 months of domestic partnership (as defined in the Domestic Partner section);
- the death of a spouse or other eligible dependent;
- the birth, adoption, or gaining legal custody of a dependent;
- a change in a dependent's eligibility status (including, but not limited to, a spouse or dependent exceeding a lifetime limit on all benefits under another employer's plan);
- the termination or commencement of your spouse or domestic partner's employment;
- a change in your employment status and that of your spouse or domestic partner;
- an unpaid leave of absence taken by you and your spouse or domestic partner;
- a significant change in your health care coverage (or spouse or domestic partner's coverage) due to your spouse's employment; or
- a change of residence.

If you have a [*qualifying event*](#) and wish to change your benefits, you must submit supporting dated documentation and enroll within 30 days of the qualifying event. Please note that the change to benefits must be consistent with the event that occurred.

Changing Coverage during the Year: After Tax

A special rule applies if you elect to pay for your coverage with after-tax contributions. In this case, you may reduce your level of coverage at any time. However, you won't be permitted to increase your level of coverage during the year, unless you have a [*qualifying family status change*](#).

For example, suppose that you elect to pay for individual plus one coverage with after-tax contributions.

You may change this election to cover only yourself at any time during the year. Once you make this change, you will not be permitted to elect individual plus one or family coverage for the balance of the calendar year unless you have a *[qualifying change in your family status](#)*.

Faculty Leaves

The university's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research leave or sabbatical leave are considered to be on full-time, active status while on leave. Therefore, your coverage will continue during your leave, as long as you continue to make the required contributions towards the cost of your benefits.

Leave without Pay

Eligible faculty and staff members who take leave without pay may be permitted to continue certain portions of their benefit coverage at their own expense. You should contact the Benefits Team in the Office of Human Resources for more information concerning the continuation of your coverage if you take leave without pay.

3.3 Understanding Your Dental Plan Options

Depending on the option you elect, you may be eligible for a limited number of covered dental services under the university's medical care benefits program. Your dental benefits program supplements and expands these services.

Eligible faculty and staff members can elect one of the following dental plan options insured through Delta Dental:

- the Basic dental plan;
- the Comprehensive dental plan; or
- no dental coverage.

Basic Dental Plan

This dental plan provides coverage for some dental services plan with dentists in the PPO network only. This means that:

You must elect a PPO Participating Dentist ("PPO"). Dentists outside the PPO network are not covered at all. To find a participating PPO dentist in your area, go to www.deltadentalins.com and click, "Find a Dentist."

A more complete description of the plan can be found in the *[Basic Dental Plan](#)*.

Comprehensive Delta Dental Plan

This dental plan provides more comprehensive dental services through a wider selection of providers:

- you can choose any dentist you want for your care;
- how much coverage you receive depends on how the dentist participates with Delta Dental:
- PPO Participating Dentist ("PPO");
- Premier Participating Dentist ("Premier"); or

- Non-Participating Dentist.

If you use a non-participating dentist, you may have to pay in full for the service and then submit your claim. To find a participating dentist in your area, go to www.deltadentalins.com and click, “Find a Dentist.”

A more complete description of the Comprehensive dental plan is in [Comprehensive Dental Plan](#).

3.4 Basic Dental Plan

You must choose a dentist in the PPO network to receive coverage. There are four important points to remember about this plan:

- the plan pays 100 percent of the PPO Allowed Amount for covered services for preventive care;
- you must satisfy an annual deductible before the plan begins to pay benefits for certain covered services (\$50 per person/year, \$150 per family/year);
- the amount that the plan pays depends on the type of covered service you receive; and
- there are maximum limits on the amounts that the plan will pay for all covered services (\$1,000 individual yearly).

When you join the Basic dental plan, you will receive an identification card. You should show your identification card to your dentist when you or an eligible dependent needs dental care.

However, your dentist also may confirm your coverage by calling Delta Dental. You should carry this card with you at all times, in case you need treatment in an emergency. If you need a replacement or extra card, you may print one off of the Delta Dental website at www.deltadentalins.com.

Selecting a Dentist in the Basic Plan

With the Basic plan, you must see a licensed dentist in the Delta Dental PPO Participating Dentist (“PPO”) network.

You and your family members can see different dentists as long as they are in the PPO network.

To take full advantage of your benefits, it is a good idea to verify a dentist’s participation status within the Delta Dental PPO network with your dental office before each appointment. Dentists in the Delta Dental Premier network or who do not participate with Delta Dental are not covered in the Basic plan, but are covered under the Comprehensive plan.

Referrals to Specialists

Your dentist may refer you to another dentist for a consultation or specialized treatment or you may elect to see a specialist on your own. If this is done, be sure that the dentist you are referred to is a PPO-participating dentist. You can do this simply by asking the specialist when you make your appointment. If the dentist is not a participating PPO dentist or if the services provided are not covered under the Basic dental plan, you will be required to pay for all of the treatment cost.

Locating a Delta Dental PPO Participating Dentist

There are several ways in which you can locate a participating dentist near you:

- you may access information about the plan through the [Delta dental website](#). This web site

includes a dentist search function allowing you to locate Delta Dental’s participating dentists by location, specialty, and network type; or

- you also may call Delta Dental and one of their representatives will assist you. They can provide you with information regarding a dentist’s membership status, specialty, and office location.

Basic Plan Benefit Summary Chart

The services provided through the plan are described in the Benefit Summary Chart on the following pages. Services not covered are described in the [Limitations and Exclusions](#) section. To help you understand the types of procedures that are included in each of the categories of services, examples and descriptions are provided in the charts. Your share may be higher than the percentages listed in the charts, depending on the applicability of deductibles, maximums, or charges for non-covered services.

The information in the following chart applies to services provided by Delta Dental PPO dentists under the Basic plan:

Delta Dental Basic Plan	
Category of Service	PPO Dentist
Deductible Individual Family	\$50 \$150
Calendar Year Maximum	\$1,000 per person
Diagnostic (deductible waived) Periodic exams (twice per calendar year) Bitewing x-rays (twice per calendar year) Full-mouth x-ray (once per 3-year period) See note on additional benefits during pregnancy	100%,* no deductible
Preventive (deductible waived) Prophylaxis (cleaning) (twice per calendar year) Fluoride treatments (twice per calendar year to age 19) Sealants (to age 14) Space maintainers (to age 14) See note on additional benefits during pregnancy	100%,* no deductible
Basic Restorative Fillings (amalgam “silver” and composite “white”)	50%,* after deductible
Oral Surgery Extraction and other oral surgery procedures, including pre- and post-operative care	50%,* after deductible
Endodontics Root canal, pulpal therapy	50%,* after deductible

Delta Dental Basic Plan	
Category of Service	PPO Dentist
General Anesthesia Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures	50%,* after deductible

*Percentages are based on the PPO Allowed Amount, which is the lesser of the dentist’s submitted charge or the PPO Maximum Plan Allowance

Basic Plan Coinsurance

The Basic plan will pay a percentage of the PPO Allowed Amount for each covered service, subject to certain limitations, and you will be responsible for paying the balance. What you pay is called coinsurance and is part of your out-of-pocket cost. You will pay this even after a deductible has been met. The amount of your coinsurance payment will depend on the type of service provided and the [*dentist providing the service*](#). Dentists are required to collect your coinsurance for covered services.

3.5 Comprehensive Dental Plan

You can use any dentist you want under the Comprehensive dental plan. There are four important points to remember about this plan:

- the plan pays 100 percent of the PPO Allowed Amount for covered services for preventive care;
- you must satisfy an annual deductible before the plan begins to pay benefits for certain covered services (\$50 per person per year, \$150 per family per year);
- the amount that the plan will pay depends on the type of covered service that you receive and the dentist’s participation in the Delta Dental network; and
- there are maximum limits on the amounts that the plan will pay for all covered services (\$1,500 individual yearly/\$1,000 orthodontics lifetime).

When you join the dental plan, you will receive an identification card. You should show your identification card to your dentist when you or an eligible dependent needs dental care. However, your dentist also may confirm your coverage by calling Delta Dental. You should carry this card with you at all times, in case you need treatment in an emergency. If you need a replacement or extra card, you may print one at www.deltadentalins.com.

Comprehensive Plan: Choice of Dentist

We recognize that many factors affect the choice of dentist and therefore we offer a plan with flexibility of choice regarding your dentist. The Comprehensive plan gives you access to a full range of dental treatments from the dental office of your choice. Under the Comprehensive plan, you may see any licensed dentist for your covered treatment:

- PPO Participating Dentist (“PPO”);
- Premier Participating Dentist (“Premier”); or
- Non-Participating Dentist.

In addition, you may choose your own specialist, and you and your family members can see different dentists. You will receive the greatest savings when you choose a PPO dentist. To take full advantage of your benefits, it is a good idea to verify a dentist’s participation status within a Delta Dental network with your dental office before each appointment.

Referrals to Specialists

Your dentist may refer you to another dentist for a consultation or specialized treatment or you may elect to see a specialist on your own. If this is done, be sure that the dentist you are referred to is a participating dentist. You can do this simply by asking the specialist when you make your appointment. Visiting a dentist who has agreed to participate in the Delta Dental network can save you money, time, and the hassle of paperwork. If the dentist is not a participating dentist, you may be required to pay all of the treatment cost at the time of service and submit a claim to Delta Dental for reimbursement.

Locating a Delta Dental Participating Dentist

There are several ways in which you can locate a participating dentist near you:

- You may access information about the plan at www.deltadentalins.com. This web site includes a dentist search function that allows you to locate Delta Dental’s participating dentists by location, specialty, and network type; or
- You also may call Delta Dental and one of their representatives will assist you. They can provide you with information regarding a dentist’s membership status, specialty, and office location.

Comprehensive Plan Benefit Summary Chart

The services provided through the plan are described in the Benefit Summary Chart on the following pages. Services not covered are described in the Limitations and Exclusions section. To help you understand the types of procedures that are included in each of the categories of services, examples and descriptions are provided in the charts. Your share may be higher than the percentages listed in the charts, depending on the applicability of deductibles, maximums, the difference between the Non-participating dentist’s fee, and the PPO Maximum Plan Allowance or charges for non-covered services.

The information in the following chart applies to services provided by Delta Dental PPO, Premier and Non-participating dentists:

Delta Dental Comprehensive Plan		
Category of Service	PPO Dentist	Delta Dental Premier Dentist and Non-Participating Dentist
Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Calendar Year Maximum	\$1,500 per person	\$1,500 per person
Orthodontia Lifetime Maximum	\$1,000 per person	\$1,000 per person

Delta Dental Comprehensive Plan		
Category of Service	PPO Dentist	Delta Dental Premier Dentist and Non-Participating Dentist
Diagnostic (deductible waived) Periodic exams (twice per calendar year) Bitewing x-rays (twice per calendar year) Full-mouth x-ray (once per 3-year period) See note on additional benefits during pregnancy	100%*	100%*
Preventive (deductible waived) Prophylaxis (cleaning) (twice per calendar year) Fluoride treatments (twice per calendar year to age 19) Sealants (to age 14) Space maintainers (to age 14) See note on additional benefits during pregnancy	100%*	100%*
Basic Restorative Fillings (amalgam “silver” and composite “white”)	90%*	80%*
Major Restorative Single crowns, inlays, onlays	60%*	50%*
Oral Surgery Extraction and other oral surgery procedures, including pre- and post-operative care	90%*	80%*
Endodontics Root canal, pulpal therapy	90%*	80%*
Surgical Periodontics Surgical treatment of the gums and supporting structures of the teeth	60%*	50%*
Non-Surgical Periodontics Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy	60%*	50%*

Delta Dental Comprehensive Plan		
Category of Service	PPO Dentist	Delta Dental Premier Dentist and Non-Participating Dentist
Prosthodontics Procedures for replacement of missing teeth by construction or repair of bridges, implants, and partial or complete dentures	60%*	50%*
Orthodontics (deductible waived) For eligible employees, spouses, and dependents to age 26 (to the end of the month)	50%*	50%*
General Anesthesia Covered when used in conjunction with covered oral surgical procedures and other selected endodontic and periodontic procedures	90%*	80%*
Denture Repair	90%*	80%*
Crown/Inlay/Onlay Repair	90%*	80%*

*Percentages are based on the PPO Allowed Amount, which is the lesser of the dentist's submitted charge or the PPO Maximum Plan Allowance

Comprehensive Plan Coinsurance

The plan will pay a percentage of the PPO Allowed Amount for each covered service, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the coinsurance and is part of your out-of-pocket cost. You pay this even after a deductible has been met. The amount of your coinsurance payment will depend on the type of service provided and the dentist providing the service (see [Choice of Dentist](#)). Dentists are required to collect your coinsurance for covered services. It is to your advantage to select PPO Dentists because they have agreed to accept the PPO Allowed Amount as payment, which typically results in lower coinsurance payments charged to you.

3.6 Deductibles, Maximum Benefits, and Additional Benefits for the Basic and Comprehensive Plans

Deductible

Most dental plans have a specific dollar deductible. The Benefit Summary Charts show the individual and family deductibles that apply. Deductibles apply to all benefits unless otherwise noted. Each enrolled family member must pay the individual deductible amount each calendar year to satisfy the plan deductible. You pay this directly to your dentist for completed services. The total deductible amount paid will not exceed the family deductible for all family members.

Maximum Benefit

Most dental programs have a maximum benefit. This is the maximum dollar amount a dental plan will pay toward the cost of dental care. You are responsible for paying costs above the maximum benefit. The Benefit Summary Charts show the maximum benefit amount that applies. This is the maximum benefit amount that the plan will pay for covered services per person in a calendar year.

Additional Benefits during Pregnancy

If you are pregnant, the plan will pay for additional services to help improve your oral health during the pregnancy. The additional services while you are covered under the contract include:

one (1) additional oral exam and choice of one (1) additional routine cleaning, or one (1) additional periodontal scaling and root planting per quadrant, or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by your dentist when the claim is submitted.

3.7 Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes limitations and exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. These limitations and exclusions are detailed carefully in this manual and you should make yourself familiar with them. Please read the section below to help you understand the limitations and exclusions of the dental plans.

Excluded Benefits

The Basic and Comprehensive plans cover a wide variety of dental care expenses, but there are some services for which the plan does not provide benefits. It is important for you to know what these services are before you visit your dentist.

The Basic and Comprehensive plans do not provide benefits for:

- treatment or materials that are benefits to a participant under Medicare or Medicaid unless this exclusion is prohibited by law;
- treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia) except for newborn children eligible at birth, so long as such eligible children continue to be enrolled;
- treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury;
- treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded;
- treatment or materials for which the participant would have no legal obligation to pay;

- services provided or materials furnished prior to the effective eligibility date of a participant under this plan, unless the treatment was a year in duration and completed after the participant became eligible if no other limitations shall apply;
- periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts;
- preventive plaque control programs, including oral hygiene instruction programs;
- myofunctional therapy, unless covered by the exception in the second bullet above;
- temporomandibular joint dysfunction, unless covered by the exception in the second bullet above;
- prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.;
- experimental procedures that have not been accepted by the American Dental Association;
- services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual participants, except this shall not apply to services commenced while the plan was in effect or the participant was eligible;
- charges for hospitalization or any other surgical treatment facility, including hospital visits;
- dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music; and
- replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

Limitations

Covered benefits to Basic and Comprehensive plan participants are limited as follows (see the Benefits Summaries for the [Basic](#) and [Comprehensive](#) dental plans for details on what is covered).

Limitation on Optional Treatment Plan

In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, and the balance of the treatment cost will be your responsibility. Optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

Limitation on Major Restorative Benefits

Replacement of crowns, jackets, inlays, and onlays will be provided no more than once in any five-year period and then only in the event that the existing crown, jacket, inlay, or onlay is not satisfactory and cannot be made satisfactory. The five-year period is measured from the date on which the restoration

was last supplied, whether paid for under the provisions of this plan, under a prior dental care contract, or by you.

Limitation on Prosthodontic Benefits

Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit, will be provided as outlined in the section [*Comprehensive Plan Benefit Summary Chart*](#).

Prosthodontic appliances and abutment crowns will be replaced only after five years following any prior provision of such appliances and abutment crowns under any plan procedure. Implants provided under any Delta Dental plan will be replaced only after five years have passed. Replacement of an implant supported prosthesis not provided under a Delta Dental program will be covered if it is unsatisfactory and cannot be made satisfactory. Implant removal is limited to once for each tooth during your lifetime.

Limitation on Orthodontic Benefits

Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of employees, spouses/partners, and dependents up to age 26, through the completion of the procedures; or to the date coverage terminates, whichever occurs first. The plan's obligation to make payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure. The plan will not make any payment for repair or replacement of orthodontic appliances.

Limitation on Oral Surgery Benefits

Benefits for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract by which you are covered shall be determined first under this plan. The plan's obligation for these oral surgery services is limited to the difference between benefits paid under other contracts up to the applicable allowed amount for the procedure less the applicable deductible and your copayment. When there is no medical or hospital coverage, the plan's obligation for oral surgery services is limited to the applicable allowed amount for those services provided under the plan less the applicable deductible and your coinsurance.

Limitation on Periodontal Surgery

Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period is measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by you.

Limitation on Sealants

Treatment with sealants as a covered service is limited to applications to eight posterior teeth.

Applications to deciduous teeth or teeth with caries are not covered services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

Limitation on Occlusal Restorations

Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the plan will only pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

3.8 How to Submit a Claim

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating dentists will fill out and submit your claims paperwork for you. Some non-participating dentists also may provide this service upon your request. If you receive services from a non-participating dentist who does not provide this service, you can submit your own claim directly to Delta Dental. You can print a claim form from Delta Dental's web site: www.deltadentalins.com. Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and mail it to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055

3.9 Payment Guidelines

Optional Treatment and Non-Covered Services

You must pay for any non-covered or optional dental services that you choose to have done.

Refer to the Limitations and Exclusions section for information about excluded services and limitations.

Often there are several approaches or different methods that a dentist may use to treat dental needs. This program is designed to cover dental treatment using standards of care consistent with the delivery of quality, affordable dental treatment to you. If you request a treatment that is more costly than standard practice, you must pay for the charges in excess of the covered dental benefit.

- Example: If a filling would fix the tooth and you choose to have the tooth crowned, you are responsible for paying the difference between the cost of the crown and the cost of the filling. You must make this payment directly to your dentist.

Pre-Treatment Estimates

If you and your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed \$300, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crowns, wisdom tooth extractions, bridges, dentures, or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pre-treatment estimate to you and the attending dentist with non-binding verification of your current availability of benefits and applicable maximums.

The pre-treatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

Other Health Insurance

Be sure to advise your dentist of all programs under which you have dental coverage and have them complete the dual coverage portion of the claim form, so that you will receive all benefits to which you are entitled. When you have coverage under more than one benefit program, the primary and secondary carriers coordinate the two programs, so that the primary carrier pays its portion first and then the secondary carrier pays its portion, not to exceed the dentist's fees for the covered services. The following rules will be followed to establish the order of determining the liability of this or any other programs:

- The program covering the participant as an employee will determine its benefits before the program covering the participant as a dependent.
- The program covering the participant as a dependent of an employee whose birthday falls earlier in the calendar year will determine its benefits before the program covering the participant as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period.
- The program covering the participant having custody of the dependent will determine its benefits first; then the program of the spouse of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.
- The program covering the participant as an employee or as a dependent of an employee will determine its benefits before one that covers the participant as a laid-off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.
- If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary," Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.
- In situations not described in the previous items, the program under which the participant has been enrolled for the longest period of time will determine its benefits first. When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program or the amount of such remaining expenses, whichever is less.

3.10 End of Coverage and Continuation Options

This section contains the following additional important information about your dental benefits:

- when your coverage ends;
- continuation of dental coverage; and
- retiree coverage.

When Your Coverage Ends

Your university-sponsored dental coverage will end on one of the following dates:

- your coverage will continue through the end of the month in which you terminate; or
- the date that your employment classification changes to a classification that is not covered by the plan; or
- the date that a specific university-sponsored dental plan is discontinued if it is the only dental coverage that you are receiving; or
- the date that the university's benefit program is terminated.

Dental coverage for a dependent will end on the last date of the month in which your dependent was eligible; or if they have turned age 26, until the end of that calendar year. For example, if an eligible dependent turns age 26 on August 18, they will be covered until December 31 of that year (see [Coverage for Your Eligible Dependents](#)).

Qualified Medical Child Support Orders

Participants and beneficiaries may obtain a description of the plan's procedures governing qualified medical child support order (QMCSO) determinations.

Extension of Benefits

The dental plan may cover expenses for a limited number of dental services following the termination of your coverage, provided that these services began before coverage ended. Some examples of such services include dentures, bridgework, crowns, and root canal therapy.

You should contact Delta Dental directly for more information concerning the extension of benefits rules, including the specific services covered.

Continuation of Dental Coverage

If dental coverage for you or an eligible dependent ends, you may be eligible to continue this coverage at your own expense. The rules for continuation of dental coverage are the same as those described in the [Medical Benefits](#) section of the Faculty Staff Benefits Manual. Please refer to the [Continuation of Health Care Coverage](#) section of the Medical Benefits section for more information.

Retiree Coverage

Faculty and staff members who have dental coverage at the time that they retire may elect to continue their dental benefits by paying the full cost of coverage.

The [Plan Administration](#) section contains additional important information about your dental benefits,

including your rights as a participant under ERISA (the Employee Retirement Income Security Act).

3.11 Complaints, Grievances, and Appeals

Delta Dental has committed to ensure quality throughout the entire treatment process. If you have questions about any services received, it is recommended that you first discuss the matter with your dentist. However, if you continue to have concerns, please call Delta Dental's Customer Service Center or the Benefits Team in the Office of Human Resources.

Delta Dental attempts to process all claims within 30 days. If a claim will be delayed more than 30 days, Delta Dental will notify you in writing within 30 days stating the reason for delay.

Questions or complaints regarding eligibility, the denial of dental services or claims; the policies, procedures, or operations of Delta Dental; or the quality of dental services performed by the dentist may be directed in writing to Delta Dental or by calling Delta Dental at (717) 766-8500 or toll-free at (800) 932-0783. You also can e-mail questions by accessing the "Contact Us" section of Delta Dental's web site at www.deltadentalins.com. A grievance is a written expression of dissatisfaction with the provision of services or claims practices of Delta Dental. When you write, please include the name of the participant, the primary participant's name and participant ID, and your telephone number on all correspondence. You also should include a copy of the claim form, benefits statement, invoice, or other relevant information.

Appeals

Any dissatisfaction with adjustments made or denials of payment should be brought to Delta Dental's attention, and if unresolved to your satisfaction, to the Benefits Team in the Office of Human Resources. The Plan Administrator will advise you of your rights of appeal or other recourse. Appeals on claims denied must be submitted in writing. The following section explains the claim review and appeal process and time limits applicable to such process. This information also can be found in your benefits statement. If a post-service claim is denied in whole or in part, Delta Dental will notify you and your attending dentist of the denial in writing within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 14 days, for processing. If there is an extension, you and your attending dentist will be notified of the extension and the reason for the extension within the original 30-day period. If an extension is necessary because either you or your attending dentist did not submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You or your attending dentist will be afforded at least 45 days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the your response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent contract provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary. The notice of denial also shall contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such

process, including a statement of the participant's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by you or your attending dentist.

If you or your attending dentist wants the denial of benefits reviewed, you or your attending dentist must write to Delta Dental within 180 days of the date on the denial letter. In the letter, you or your attending dentist should state why the claim should not have been denied. Also, any other documents, data, information, or comments which are thought to have bearing on the claim, including the denial notice, should accompany the request for review. You or your attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to you or your attending dentist on request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination. If after review, Delta Dental continues to deny the claim, Delta Dental will notify you and your attending dentist in writing of the decision on the request for review within 30 days of the date the request is received. Delta Dental will send to you or your attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific contract provisions on which the benefit determination is based. The notice shall state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by either you or your attending dentist. The notice also shall state that you have a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

If, in the opinion of you or your attending dentist, the matter warrants further consideration, you or your attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if

requested by you or your attending dentist. The Dental Affairs Committee will render a decision within 30 days of the request for further consideration. The decision of the Dental Affairs Committee shall be final as far as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

Send your grievance, appeal, or claims review request to Delta Dental at the address shown below:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

Participant complaints regarding carriers can be sent to the District of Columbia Life and Health Guaranty Association and/or to the District of Columbia Department of Insurance Securities, and Banking.

3.12 General Program Information

Proof of Claim

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an participant as may be required to administer the claim, or that an participant be examined by a dental consultant retained by Delta Dental, in or near the community or residence. Delta Dental will in every case hold such information and records confidential.

Physical Access

Delta Dental has made efforts to ensure that their offices and the offices and facilities of Participating Dentists are accessible to the disabled. If you are not able to locate an accessible dentist, please call their Customer Service Center and a representative will help you find an alternate dentist.

Access for the Hearing Impaired

The hearing impaired may contact the Customer Service Center through Delta Dental's toll-free TTY/TDD number at (888) 373-3582.

4.0 Life Insurance

4.1 Introduction

Full-time faculty and staff members of American University receive fully paid basic life insurance and accidental death & dismemberment (AD&D) benefits, and may elect optional life insurance and optional accidental death & dismemberment (AD&D) insurance coverage.

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided, the eligibility rules, or any other feature of the plan. Your participation in the university's benefit program does not guarantee your employment with the university for any length of time.

4.2 Eligibility and Participation

Participation in the university's group life insurance program provides you with:

- Basic life insurance at no cost to you – basic coverage equal to one times your annual salary, rounded to the next higher \$1,000 (\$650,000 maximum);
- Basic accidental death & dismemberment (AD&D) insurance at no cost to you – amount equal to your basic life insurance amount (\$650,000 maximum);
- the opportunity to purchase optional life insurance equal to an additional one to five times your annual salary, rounded up to the next higher \$1,000 (\$1,500,000 maximum);
- the opportunity to purchase optional life insurance of up to \$100,000 for your spouse or domestic partner, or up to \$10,000 for each dependent child;
- an accelerated death benefit option for you and your spouse or domestic partner if diagnosed with a terminal illness;
- the opportunity to enroll in accidental death & dismemberment (AD&D) insurance in amounts ranging from one to ten times your base annual salary (\$500,000 maximum);
- the opportunity to elect accidental death & dismemberment (AD&D) insurance of up to \$250,000 for your spouse or domestic partner and up to \$75,000 for each dependent child.

Your life insurance benefits are provided through a group benefit contract between the university and Prudential.

Eligibility

You are eligible to participate in the group life insurance program if you are:

- a full-time faculty member; or
- a regular, full-time staff member.

Full-Time Faculty Member

You are considered to be a full-time faculty member if you currently have a contract as a full-time faculty member and receive remuneration.

Regular, Full-Time Staff Member

You are considered to be a regular, full-time staff member if:

- your position is classified as full time; and
- you are scheduled to work for at least 28 hours per week.

You are not eligible for participation in the group life insurance program if you are working on a part-time or temporary basis. If you are not certain about your eligibility for participation, please contact the Benefits Team in the Office of Human Resources.

Legal Spouse

For plan purposes, the term “spouse” refers to the legal spouse of the employee.

Domestic Partner

For plan purposes, “domestic partners” refers to persons of the same or opposite gender who have a completed document-supported Domestic Affidavit on file with human resources and:

- are registered as each other’s domestic partner, civil union partner, or reciprocal beneficiary with a government agency where such registration is available; or
- can certify that they:
- both are at least 18 years of age and mentally competent to consent to a legally binding contract;
- are each other’s sole domestic partner and intend to remain in this relationship indefinitely;
- share a close, personal relationship and are responsible for each other’s common welfare;
- share the same primary residence (and have shared this residence for the past twelve months) and intend to do so indefinitely;
- are not married to anyone of the same or opposite sex nor have had another domestic partner within the past twelve (12) months;
- are not related by blood closer than would bar marriage in the District of Columbia or the state they live in;
- are financially interdependent on each other; and
- are able demonstrate their joint responsibility to each other’s common welfare and financial interdependence for a minimum of 12 months.

Dependent Children

As long as you are covered, you may elect coverage for your dependent children who are at least 14 days old and under age 23 (or under age 25 if they are a full-time student). Children must be dependent on you for support, unmarried, and not employed on a full-time basis.

Dual Coverage

No one may be covered more than once under this plan. If covered as an employee, you cannot also be covered as a dependent.

Actively-at-Work

To be eligible for group life insurance coverage, you must be actively-at-work on the date that your coverage is scheduled to begin. You are considered to be actively-at-work if

- 1) you are performing all your normal duties for the usual number of hours and rate of pay, and

- 2) you are at your normal place of employment with the university, or on required travel for the university. You also are considered to be actively-at-work on each day of paid vacation, during excused absence for sickness or disability, and on each scheduled day off.

If you are not actively-at-work on the date that your group life insurance coverage normally would be scheduled to begin, your coverage will become effective as of the date that you return to being actively-at-work.

For your spouse or domestic partner coverage and/or children's coverage to be effective, they must not be hospitalized, confined at home under the care of a doctor, or receiving disability benefits.

Cost

Your basic life insurance and accidental death & dismemberment (AD&D) insurance are provided at no cost to you. If you elect optional life insurance or AD&D insurance coverage, you pay for this coverage through convenient payroll deductions.

When Basic Life and AD&D Insurance Coverage Begins

Eligible faculty and staff members automatically become covered by Basic Life Insurance and AD&D Insurance on the first day of the month following their date of hire. (If your date of hire is the first day of the month, your coverage will be effective on that day.)

A more complete description of Basic Life Insurance and AD&D Insurance starts at Section 4.3 [*Basic Life Insurance and Accidental Death & Dismemberment Insurance*](#).

New faculty or staff members who are eligible to participate ([*Section 4.2 Eligibility and Participation*](#)) may enroll for Optional Life insurance benefits during their first 30 days of full-time employment with the university. This coverage will begin on the first day of the month following the date that the insurance company receives your completed enrollment application.

If you do not enroll within 30 days of your date of hire, you will not be eligible for to apply for Optional Life until the annual open enrollment period and certain restrictions will apply (see [*Annual Re-Enrollment for Optional Coverage*](#)).

Electing Optional Life Insurance for Dependents

Your dependents (spouse, domestic partner, child[ren]) will be eligible for coverage if you complete your online enrollment. Your dependent's coverage will take effect either when your coverage takes effect or when they become eligible (whichever is later).

Electing Accidental Death & Dismemberment (AD&D) Insurance for Self & Family

New faculty or staff members who are eligible to participate see ([*Section 4.2 Eligibility and Participation*](#)) may enroll themselves and their family for accidental death & dismemberment (AD&D) insurance benefits during their first 30 days of full-time employment with the university. This coverage will begin on the first day of the month following the date that the insurance company receives your completed enrollment application.

If you do not enroll within 30 days of your date of hire, you and your family will not be eligible for to apply for AD&D insurance benefits until the annual open enrollment period and certain restrictions

will apply (see [Annual Re-Enrollment for Optional Coverage](#)).

Faculty Leaves

The university's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research leave or sabbatical leave should contact the Benefits Team in the Office of Human Resources for more information concerning continuation of your life insurance coverage during your leave.

Leave without Pay

Eligible faculty and staff members who take leave without pay may be permitted to continue certain portions of their benefit coverage at their own expense. You should contact the Benefits Team in the Office of Human Resources for more information concerning the continuation of your coverage if you take leave without pay.

Changing Coverage during the Year

The coverage level you elect as a new employee or during the open enrollment period will remain in effect during the next calendar year. You can change this election during the year only if your family status changes. Changes in family status include:

- marriage, divorce, and legal separation or annulment;
- 12 months of domestic partnership (as defined in the [Domestic Partner section](#));
- the death of a spouse and other eligible dependent;
- the birth, adoption, placement for adoption and gaining legal custody of a dependent;
- the termination or commencement of your spouse or domestic partner's employment;
- a change in your employment status and that of your spouse or domestic partner (including the beginning or ending of a strike or lockout); and
- an unpaid leave of absence taken by you and your spouse or domestic partner.

If you have a Qualifying Event and wish to change your benefits, you must submit supporting dated documentation and enroll within 30 days of the qualifying event. Please note that the change to benefits must be consistent with the event that occurred.

4.3 Basic Life Insurance and Accidental Death & Dismemberment Insurance

As a full-time faculty or staff member, you receive Basic Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance coverage. The university pays the full cost of this coverage on your behalf.

Basic Life Insurance

Your Basic Life Insurance benefit is one times your annual salary, rounded up to the next higher \$1,000. The maximum Basic Life Insurance benefit payable is \$650,000.

For example, assume that your annual salary is \$64,700. If your death occurs during active employment, your beneficiary will receive a Basic Life Insurance benefit of \$65,000 (\$64,700 rounded up to the next higher \$1,000 = \$65,000).

If your death is due to an accidental injury, your beneficiary may be eligible for an additional Accidental Death & Dismemberment benefit (see below).

Definition of Annual Salary

For plan purposes, your annual salary is your annual base salary only. It does not include overtime, stipends, shift differentials, summer teaching, overload payments for full-time faculty, or other forms of additional compensation.

Any change in your earnings that affects the amount of your annual salary will go into effect on the date of change occurs. If you are not actively-at-work (see Eligibility: [Actively-at-Work](#)) on the date that an increase in your annual salary would otherwise have occurred, this increase will go into effect on the date that you return to being actively-at-work.

Basic Accidental Death & Dismemberment Insurance

Basic Accidental Death & Dismemberment (AD&D) Insurance will pay an additional benefit in the event of certain kinds of losses as the direct result of an accidental injury. This applies only if:

- the loss is independent of all other causes; and
- the loss occurs within 365 days of the accidental injury; and
- the loss is not due to suicide, intentionally self-inflicted injury, or another cause that is not covered by the plan (see [Certain Losses Are Not Covered](#)).

It is important to remember that the Basic AD&D benefit is payable in addition to the benefit payable from Basic Life Insurance. For example, suppose your Basic Life Insurance benefit is

\$65,000. If your death occurs as the direct result of a covered accident, your beneficiary will receive a total benefit of \$130,000.

Amount of Benefit

As the following table shows, the amount of the AD&D Insurance benefit payable depends on the type of loss suffered.

Basic Accidental Death & Dismemberment Insurance Benefits	
Type of Loss	Benefit Payable (% of Benefit Amount)
Loss of life	100%
Total paralysis of both upper and lower limbs Loss of any two hands, feet, or eyesight	100%
Loss of speech and hearing in both ears	
Loss of one arm or one leg	75%

Basic Accidental Death & Dismemberment Insurance Benefits	
Type of Loss	Benefit Payable (% of Benefit Amount)
Loss of one eye, hand, or foot	50%
Loss of speech or loss of hearing in both ears	
Total paralysis of both legs	
Total paralysis of arm and leg on one side of the body	
Loss of thumb and index finger of the same hand	25%

If the same accident causes more than one of these losses, the insurance company will pay only one amount, but it will be the largest amount that applies.

Loss of hand means complete severance at or above the wrist, but below the elbow. Loss of foot means complete severance at or above the ankle, but below the knee. Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees. Loss of speech means the entire and irrecoverable loss of speech that continues for six consecutive months following the accidental injury. Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for six consecutive months following the accidental injury. Loss of thumb and index finger of the same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb. Paralysis means loss of use without severance of a limb. This loss must be determined by a doctor to be complete and not reversible.

Common Disaster

If you and your spouse or domestic partner are injured in the same accident and die within 365 days as a result of injuries sustained in such accident, the full amount paid for your spouse or domestic partner's loss of life will be increased to equal the full amount payable for your loss of life.

Maximum Basic AD&D Benefit

The maximum benefit that Basic AD&D Insurance will pay for the same accident is the full benefit for loss of life. For example, suppose your Basic Life Insurance benefit is \$65,000. If you become dismembered and then die as the result of the same accident, the maximum AD&D benefit payable to your beneficiary is \$65,000.

In the above example, the total benefit payable to your beneficiary is \$130,000 (\$65,000 from Basic Life Insurance, plus \$65,000 from Basic AD&D Insurance).

Certain Losses Are Not Covered

Plan benefits are not payable for a loss that results, directly or indirectly, from any of the following circumstances:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;

- infection, other than infection occurring in an external accidental wound;
- suicide or attempted suicide;
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority, except the United States National Guard; or
- any incident related to:
 - travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger;
 - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
 - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
 - travel in an aircraft or device used for testing or experimental purposes, by or for any military authority or for travel beyond the earth's atmosphere.
 - committing or attempting to commit a felony;
 - the voluntary intake or use by any means of:
 - any drug, medication or sedative, unless it is taken or used as prescribed by a physician or an "over the counter" drug, medication or sedative taken as directed;
 - alcohol in combination with any drug, medication, or sedative; or poison, gas, or fumes.
 - war, whether declared or undeclared, or act of war, insurrection, rebellion, or riot.

Exclusion for Intoxication

Plan benefits will not be paid if any loss is incurred while the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

If you have any questions concerning your AD&D Insurance coverage, you can contact the Benefits Team in the Office of Human Resources.

Tax Considerations

AU pays the entire cost of these benefits. Please note that the premium for basic life insurance coverage in excess of \$50,000 is imputed income. The IRS requires that the value of the premium for basic life insurance benefits in excess of \$50,000 for federal income tax purposes be subject to taxation. The value of the premium for this benefit is considered income to you and is added to your total income for tax purposes. This added "income" is called imputed income.

4.4 Optional Life Insurance

You pay for this coverage through convenient payroll deductions. If you do not apply for Optional Life Insurance within 30 days of the date that you are hired, you will be required to provide evidence of insurability (proof of good health) to the insurance company before your application for Optional Life Insurance can be approved.

Optional Life Insurance Options

You can elect Optional Life Insurance coverage equal to an additional one to five times annual salary. Keep in mind that the term “annual salary” has a specific definition under the plan. This is explained in the [Definition of Annual Salary](#) section of Basic Life Insurance.

Maximum Benefit

The maximum amount of Optional Life Insurance coverage that you can elect is the lesser of five times your base annual salary or \$1,500,000. You may purchase a guaranteed coverage amount of the lesser of four times your base annual salary or \$600,000 without medical evidence of insurability or proof of good health.

How Your Benefit Is Determined

When your Optional Life Insurance benefit is determined, it will be rounded up to the next higher \$1,000. It is also important to remember that your Optional Life Insurance benefit is payable in addition to any amounts that your beneficiary may be entitled to receive under Basic Life Insurance and AD&D Insurance (see Basic Life Insurance).

For example, assume that your death occurs during active employment with the university. Also assume that:

- your annual salary as of your date of death is \$64,700;
- you have Optional Life Insurance coverage on your date of death equal to 3x your annual salary; and
- your death is not due to an accidental injury.

In the above example, your beneficiary would be eligible to receive an Optional Life Insurance death benefit of \$195,000 ($\$64,700 \times 3 = \$194,100$ rounded up to \$195,000). This benefit would be in addition to the university-provided Basic Life Insurance which also would provide a \$65,000 benefit in this example.

Optional Life Insurance Options for Your Spouse or Domestic Partner

You can elect Optional Life Insurance coverage for your spouse or domestic partner in units of \$10,000 to \$100,000. The cost of your spouse or domestic partner's coverage will be based on your spouse or domestic partner's age. You may purchase a guaranteed coverage amount of \$10,000 for your spouse or domestic partner without medical evidence of insurability or proof of good health.

Optional Life Insurance Options for Your Unmarried, Dependent Children

You can elect Optional Life Insurance coverage for your unmarried, dependent children in units of \$1,000 up to a maximum of \$10,000. You may purchase a guaranteed coverage amount of \$10,000 for your dependent children without medical evidence of insurability or proof of good health.

Guaranteed Coverage for Optional Coverage

If you and your dependents are eligible and you apply within 31 days after you are eligible to elect coverage, you are entitled to choose any of the offered amounts of coverage up to the guaranteed

coverage amount without having to provide evidence of good health.

If you apply for an amount of coverage for yourself and any dependents greater than the guaranteed coverage amount in excess of the guaranteed coverage amount, the excess coverage will not be issued until the insurance company approved the acceptable evidence of your good health. Evidence of good health may include a paramedical exam or physician's statement.

If you or your dependents apply for an amount of life insurance coverage greater than the guaranteed issue amount, or apply 31 days after you or your dependents become eligible, the coverage will take effect on the date the insurance company agrees in writing to cover you or your dependents. The insurance company will require evidence of good health and may require it to be provided at your expense.

Annual Re-Enrollment for Optional Life Insurance

Each fall, during the open enrollment period, you have the opportunity to increase your Optional coverage. The insurance company will require no medical evidence of insurability for additional amounts equal to one benefit level increase subject to the original guaranteed coverage amount. The insurance company requires medical underwriting for larger amounts, as well as for employees who have been declined previously for coverage or who did not participate in the plan when initially eligible.

Automatic Increase Feature for Optional Life Insurance

When there is an increase in your base annual salary, your Optional Life Insurance coverage will be increased accordingly – not to exceed your guaranteed coverage amount of \$600,000.

The new coverage amount will become effective on the date of the change. However, if the increase in coverage is to an amount in excess of the plan's guaranteed coverage amount of \$600,000, and you had not applied previously and been approved by the insurance company for coverage in excess of the guaranteed coverage amount, you must receive approval from the insurance company in order for the benefit increase to become effective.

Tax Considerations

Under current government regulations, any Optional Life Insurance benefits that your beneficiary is entitled to receive will be payable on a tax-free basis.

4.5 Accelerated Death Benefit Options

Your Basic Life Insurance and your spouse or domestic partner's Optional Life coverage provide for the payment of benefit to participants who are diagnosed with a terminal illness and have a life expectancy of less than 12 months. This benefit feature is described below.

Accelerated Death Benefit Option for Terminal Illness

A portion of your Basic Life Insurance benefit and your spouse or domestic partner's Optional Life benefit may be payable while you or your spouse or domestic partner are terminally ill. This Accelerated Death Benefit option can be an important source of income for yourself and your family during this difficult period.

Eligibility for Accelerated Death Benefit for Terminal Illness

The Accelerated Death Benefit may be requested only once during an individual's lifetime. You can request that up to 80 percent of the coverage amount in force to be paid to you (to a maximum of \$500,000 for your Basic Life Insurance and \$80,000 for your spouse or domestic partner's Optional Life Insurance).

This benefit is available only if:

- you are eligible for group life insurance coverage, and your coverage under the group life insurance policy is valid and in force; and
- the amount of benefit to be accelerated is equal to or greater than \$10,000; and
- you or your spouse or domestic partner are diagnosed by a physician as terminally ill with a life expectancy of 12 months or less; and
- you submit a written request for the Accelerated Death Benefit to the insurance company.

Effect on Life Insurance Coverage

If you receive an Accelerated Death Benefit payment for you or your spouse or domestic partner, the amount of your Basic Life Insurance or your spouse or domestic partner's Optional Life Insurance coverage (whichever is impacted) will be reduced by the Accelerated Death Benefit payment. Upon your death or your spouse or domestic partner's death, you or your beneficiary will receive the remaining amount.

Applying For Benefits

You can apply for the Accelerated Death Benefit by completing the appropriate form, which you can obtain from the insurance company. Your completed claim form must be accompanied by a written medical opinion from a physician, including:

- the physicians' diagnosis of your or your dependent's condition; and
- the physicians' prognosis that death is expected within 12 months; and
- the physicians' reasons for the prognosis, along with supporting evidence.

Additional Medical Opinion(s)

The insurance company may require an additional medical opinion from a physician chosen by the insurance company (and at the insurance company's expense).

Assignment of Benefits

If you have assigned your life insurance or named an irrevocable beneficiary, you are not eligible for the Accelerated Death Benefit.

Final Decision

The final decision concerning payment of the Accelerated Death Benefit is reserved to the insurance company.

Accelerated Death Benefit Exclusions

The Accelerated Death Benefit is not payable under certain circumstances. The Accelerated Death Benefit will not be paid if:

- your life insurance under the group insurance policy is not in force or is invalid or void for any reason;
- any premium due under the group insurance policy is unpaid; or
- you already have received an Accelerated Death Benefit under any policy issued by the insurance company.

You can use your Accelerated Death Benefit payment for any purpose. However, please remember that the Accelerated Death Benefit is not a long-term care policy. The amount of your payment may not be enough to cover nursing home expenses or other bills.

4.6 Accidental Death & Dismemberment (AD&D) Insurance

Accidental death & dismemberment (AD&D) insurance helps protect you against losses due to accidents. The insurance company will pay the full benefit amount for accidental loss of life occurring within 365 days of a covered accident. To help survivors of severe accidents adjust to new living circumstances, the insurance company will pay benefits for paralysis, dismemberment and loss of eyesight, speech and/or hearing.

Enrollment for AD&D insurance is completely voluntary. You can enroll for AD&D insurance coverage during your first 30 days of full-time employment with the university. This coverage will begin on the first day of the month following the date that you enroll.

If you do not enroll within 30 days of your date of hire, you will not be eligible for to apply for AD&D insurance until the annual open enrollment period.

Accidental Death & Dismemberment (AD&D) Insurance Coverage

You can elect accidental death & dismemberment (AD&D) insurance coverage equal to an additional one to ten times your annual salary.

Keep in mind that the term “annual salary” has a specific definition under the plan. This is explained in the Definition of Annual Salary section of the Basic Life Insurance.

Maximum Benefit

The maximum amount of AD&D insurance coverage that you can elect is lesser of ten times your base annual salary or \$500,000.

Under the common disaster provision, if you and your spouse or domestic partner are injured in the same accident and die within a year as a result of injuries sustained in the accident, the full amount paid for your spouse or domestic partner’s loss of life will be increased to equal the full amount of your AD&D insurance benefit.

Accidental Death & Dismemberment Insurance for your Family

You can elect accidental death & dismemberment (AD&D) insurance coverage for your family. You can cover your spouse or domestic partner in an amount equal to 40 percent of the coverage you elect for yourself, or 50 percent of the coverage you elect for yourself, if you have no dependent children. The maximum amount of AD&D insurance coverage that you can elect for your spouse or domestic partner is \$250,000.

You also can cover your unmarried, dependent children in an amount equal to 10 percent of the coverage you elect for yourself, or 15 percent of the coverage you elect for yourself if you are a single parent. The maximum amount of AD&D insurance coverage that you can elect for your unmarried, dependent children is \$75,000 for each child.

Each family member's coverage is a percentage of the benefit amount you select. It will depend on who your insured family members are at the time of a covered accidental loss.

College Education Feature

If you die in a covered accident, the insurance company will pay an extra benefit for each insured child who is enrolled in college or is in the 12th grade and enrolls in college within one year of the accident. To help pay college expenses, the insurance company will pay an amount equal to the tuition charges incurred up to \$10,000 per academic year and not to exceed an overall maximum of 20 percent of your AD&D insurance benefit in effect on the date of the accidental injury. This benefit is payable each year for four consecutive years as long as your children continue their college education. If you do not have a qualifying child, the insurance will pay an additional \$1,000 to your beneficiary.

If you die in a covered accident, the insurance company will pay an extra benefit for your spouse or domestic partner if they were enrolled as a full-time student in college or if they enroll in college within one year of the accident. The insurance company will pay an amount equal to the tuition charges incurred up to \$5,000 for one academic year and not to exceed an overall maximum of 3 percent of your AD&D insurance benefit in effect on the date of the accidental injury.

The university also offers continued Educational Benefits to children of faculty and staff, depending on their length of service at the time of death. Please consult [Section 8.0 Education Benefits](#) of the Faculty Staff Benefits Manual for more information.

Wearing a Seatbelt Feature

This benefit is payable if you or your covered dependent dies as a result of injuries sustained in a covered accident while driving or riding in a private passenger car equipped with seatbelts. For the purposes of this benefit, a validly registered four-wheel private passenger (or policyholder-owned) is a car, station wagon, jeep, pickup truck, or van-type care that is not licensed commercially or being used for commercial purposes or any vehicle used for recreational or professional racing. If the insured person has been protected by a properly fastened seatbelt (or if the insured child, by a child restraint as defined by state law), a payment of 10 percent of your combined basic AD&D benefit and your optional AD&D insurance benefit will be made (the amount will not be less than \$1,000 nor more than \$25,000).

No benefit is payable if the official accident report is either not available or indicates that no seatbelt was worn.

Using an Air Bag Feature

This benefit is payable if you or your dependent dies as a result of injuries sustained in a covered accident while driving or riding in a private passenger car with properly installed air bags and positioned in a seat protected by an air bag. For the purposes of this benefit, a validly registered four-wheel private passenger (or policyholder-owned) is a car, station wagon, jeep, pickup truck, or van-type care that is not licensed commercially or being used for commercial purposes or any vehicle used for recreational or professional racing. If the insured person has been protected by a properly fastened seatbelts (or if the insured child, by a child restraint as defined by state law) and was riding in a seat protected by an air bag, a payment of 5 percent of your combined basic AD&D benefit and your optional AD&D insurance benefit will be made (the amount will not be less than \$1,000 nor more than \$10,000).

No benefit is payable if the official accident report is either not available or indicates that no seatbelt was worn.

Child Care Feature

If you die as a result of an accidental injury, the insurance company will pay an extra benefit if your child is under age 12 and is enrolled in a child care center or becomes enrolled in a child care center within one year of the accident. A child care center is operated and licensed according to the law of the local jurisdiction and provides care and supervision for children in a group setting on a regularly scheduled and daily basis. A payment of 12 percent of your AD&D insurance benefit will be made (to a maximum amount of \$5,000).

Hospital Confinement Feature

If you or your dependent is confined in the hospital as the result of an accidental injury, the insurance company will pay an amount for each full month of hospital confinement for up to one year. A monthly payment of 1 percent of your AD&D insurance benefit will be made (to a maximum amount of \$2,500 per month).

Common Carrier Feature

If you or your dependent dies as a result of an accidental injury while traveling in a common carrier, optional AD&D insurance benefits. A common carrier is a government regulated entity that is in the business of transporting fare paying passengers.

Certain Losses are Not Covered

Refer to [*Certain Losses Are Not Covered*](#) for details on losses that are not covered.

4.7 Claim Filing Procedure

Claim forms may be obtained from the Benefits Team in the Office of Human Resources. The completed claim form should be returned to the Benefits Team in the Office of Human Resources, who then will forward it to the insurance company. The claim will be considered to be filed when it is received by the insurance company.

Denied Claims

If all or a portion of your claim for group life insurance benefits is denied, you will be notified, in writing, of the denial as well as the specific reasons for it. Under normal circumstances, you will receive this notification within 90 days of the date you file the claim. Under special circumstances, you may receive a written notification to extend this period by an additional 90 days. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the end of the initial 90-day period. In no event will the extension period exceed a period of 90 days from the end of the initial period. The notice of denial will include the following information:

- the specific reasons for the denial;
- reference to the plan provisions on which the denial is based;
- a description of additional information required for the claim; and
- an explanation of the procedure for appeal including the time limits and statement of your right to bring a civil action under section 502(a) of ERISA.

Appealing a Denied Claim

You (meaning you are the insured employee or claimant) or someone acting for you may appeal a denial of benefits for any claim or portion of a claim within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. The appeal should be in writing and include a copy of the correspondence denying your claim, a statement of why you feel the decision is incorrect, and documentation supporting your statement citing plan provisions where appropriate.

Appeals can be sent via regular mail to the following P.O. Box. Please be sure the documentation states “appeal” at the top of the first page, and include the claim number.

Prudential Group Life Claims Attn: Appeal
P.O. Box 8517
Philadelphia, PA 19176

Appeals can be overnighted to the following street address. Again, please be sure the documentation states “appeal” at the top of the first page with the claim number listed.

Prudential Group Life Claims Attn: Appeal
2101 Welsh Road
Dresher, PA 19025

Additionally, Life claim appeals can be faxed to 888-227-6764, addressed to “Attn: Appeal” with the claim number.

Appeals can also be emailed to grouplifeclaims@prudential.com — including “Attn: Appeal” with the claim number.

You or your authorized representative has the right to review documents pertinent to the denied claim. Your claim will be reviewed, and in most cases, a final decision will be sent to you within 45 days of the date that your appeal is received. Under special circumstances, you may receive a written notification extending this period by an additional 45 days. The written notification of the final decision will explain the reasons for the decision as well as references to the plan provisions upon which the

decision was based.

4.8 Additional Important Information

This section contains additional important information about your life insurance benefits:

- naming your beneficiary;
- total disability benefit;
- when your coverage ends; and
- the conversion privilege.

Naming Your Beneficiary for Life and Accidental Death & Dismemberment Insurance

If you do not designate a specific beneficiary, your benefit will automatically be paid to the first benefit listed below who is living at the time of your death:

- your spouse;
- your child(ren);
- your parents;
- your siblings; or
- your estate.

If you wish to designate different beneficiaries, or to indicate percentages paid to multiple beneficiaries, you may do so on the myBenefits online site. If the listed beneficiary is a trustee or a trust, you will need to indicate the trustee's name, the name of the trust, and the date of the trust agreement. The trust document must be presented in order for the claim to be processed.

It is important for you to keep your beneficiary designation up to date. You can change your beneficiary at any time on the myBenefits online site. The beneficiary information on the myBenefits site supersedes any previous documentation provided to the university.

Total Disability Benefit

If you become totally disabled, to make sure that you keep the life insurance protection you need during a difficult period of your life, this plan provides a waiver of premium feature. If you are totally disabled and cannot work for at least six months, you will not need to pay premiums for your coverage while you are disabled. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because injury or sickness. This benefit is subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or domestic partner or children, the premium for their coverage also is waived.

This applies only if:

- the insurance company receives satisfactory proof that you are totally disabled; and
- you surrender any individual policy that was issued to you under the conversion privilege (see [*Converting Your Coverage to Permanent Life Insurance*](#));
- The waiver of your premiums will continue until the date that you recover from your total disability.

Definition of “Total Disability”

For plan purposes, you are considered to be totally disabled if, due to injury or sickness, you are unable to do any gainful work or to perform any occupation for which you are qualified based on education, training, or experience.

The insurance company may require you to submit continuing proof of your disability that is satisfactory to the insurance company. The insurance company also may require you to take a physical examination at any time to verify your continued eligibility for total disability benefits.

When Your Coverage Ends

Your university-sponsored group life insurance and accidental death & dismemberment (AD&D) insurance will end on any of the following dates:

- the date that you leave full-time employment with the university, or cease to be actively at work (see Basic Life Insurance: [*Actively-at-Work*](#));
- the date that your employment classification changes to a classification that is not covered by the plan;
- the date that a specific university-sponsored group life and accidental death & dismemberment insurance plans are discontinued; or the date that the university’s benefit program is terminated.

If You Leave the University

To help you keep your coverage during the years when your family needs financial protection, the plan allows you to continue all of your voluntary coverage if you leave the university. Premiums may change at this time. Just make arrangements to pay your premiums directly to the insurance company after you leave the university. Coverage also may be continued for your children. As long as the group policy remains in force, the option of continuing this coverage is available.

Converting Your Coverage to Permanent Life Insurance

If your group life insurance coverage ends for any reason except for nonpayment of premiums, you can convert your coverage to an individual policy that is issued by the insurance company. (The conversion amount may be reduced if you lose your coverage due to a change in your employment classification or the university’s cancellation of its group insurance policy with the insurance company.) No medical certification is needed.

To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days of the date that your coverage ends.

Family members also may convert their coverage as well. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed. Premiums may change at this time.

Death Benefit

If you die within the first 31 days after becoming eligible for the conversion privilege, the insurance company will pay your beneficiary a death benefit equal to the amount of life insurance you had on your date of termination.

The Plan Administration section contains additional important information about your life insurance benefits, including your rights as a participant under ERISA (the Employee Retirement Income Security Act).

4.9 Death While In Active Service

The university provides an additional benefit. When a full-time staff or faculty member with ten years or more of continuous full-time service to the university dies while on the active rolls of the university, the university will pay a lump sum equal to twenty percent of the base annual salary to the decedent's estate.

5.0 Short Term Medical Leave & Disability

5.1 Introduction

An unexpected injury or illness can have a serious impact on your financial resources. Eligible faculty and staff members of American University receive benefits in the event of both short term medical and long term disability.

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided, the eligibility rules, or any other feature of the plan. Your participation in the university's benefits program does not guarantee your employment with the university for any length of time.

5.2 Short Term Medical Leave & Disability Benefits Eligibility and Participation

Participation in the university's short term medical leave and disability benefits program provides you with:

- up to six months of short term medical leave (STML) coverage for short term illnesses or injuries; and
- Long Term Disability (LTD) coverage in the event that you become totally disabled.

Eligibility

You are eligible to participate in the disability benefits program if you are:

- a full-time faculty member; or
- a regular, full-time staff member.

Full-Time Faculty Member

You are considered to be a full-time faculty member if you currently have a contract as a full-time faculty member and are receiving remuneration.

Regular, Full-Time Staff Member

You are considered to be a regular, full-time staff member if:

- your position is classified as full-time; and
- you are scheduled to work for at least 28 hours per week.

You are not eligible for participation in the disability benefits program if you are working on a part-time basis. If you are not certain about your eligibility for participation, please contact the Benefits Team in the Office of Human Resources.

Actively-at-Work

You are considered to be actively-at-work if you are performing the usual and customary duties of your job on a full-time basis.

Definition of Annual Salary

For plan purposes, your annual salary is your annual base salary only. It does not include overtime, stipends, shift differentials, or other forms of additional compensation.

Any change in your earnings that affects the amount of your annual salary will go into effect on the date the change occurs. If you are not actively-at-work on the date that an increase in your annual salary would otherwise have occurred, this increase will go into effect on the date that you return to being actively-at-work.

Cost

Short term medical leave benefits are provided at no cost to you. You share the cost of your long term disability coverage with the university through convenient payroll deductions.

When Short Term Medical Leave (STML) Coverage Begins

Staff Members

If you are an eligible staff member (see [Eligibility](#)), your coverage under STML will begin after you have completed six months of continuous full-time service with the university (including use of any annual leave and sick leave). Leave without pay does not count towards this six-month period.

Faculty Members

STML coverage for eligible faculty members (see [Eligibility](#)) begins on the first day of full-time employment with the university.

When Long Term Disability (LTD) Plan Coverage Begins

Eligible faculty and staff members become covered by the LTD Plan as of the day following their completion of 12 months of continuous full-time service with the university. Any period(s) of leave without pay will not count towards this 12 months of service requirement.

Participation in the LTD Plan is mandatory for all eligible faculty and staff members who were hired on or after April 1, 1968. You will be notified of your required monthly contribution towards the cost of your coverage shortly before your participation begins.

You must be actively-at-work on the date that your coverage under the LTD Plan is scheduled to begin. If you are not actively-at-work on that date, your coverage will begin on the date of your return to active work with the university.

Faculty Leaves

The university's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research leave or sabbatical leave are considered to be on full-time, active status while on leave. Therefore, your STML coverage will continue during your leave. Human resources will work with you to ensure your LTD Plan coverage is paid so that your coverage continues while you are on leave.

Leave without Pay

Eligible faculty and staff members who are on leave without pay may be permitted to continue certain portions of their benefit coverage at their own expense. You should contact the Benefits Team in the Office of Human Resources for more information concerning the continuation of your coverage if you take leave without pay. When your department approves leave without pay, the Benefits Team in the Office of Human Resources will contact you about making arrangements to continue your LTD premium and specified benefit premiums while you are on leave.

5.3 Short Term Medical Leave Benefits

The Short Term Medical Leave (STML) benefit provides you with up to 26 weeks of income protection if you are unable to work due to a non-occupational illness or injury. The university pays the full cost of this plan.

The District of Columbia Universal Paid Family Leave Act (UPLAA) provides the following government administered paid family leave benefits (PFL) to employees who work for an employer in the District. The law allows qualifying paid medical leave for up to a maximum of 2 workweeks within a 52-workweek period for one's own serious medical condition. For more information, please see DC University Paid Family Leave in the [Legally Required Benefits](#) section of this manual.

Employee access to PFL benefits begins on July 1, 2020. This program for eligible employees is funded fully by a tax paid by American University to the District of Columbia.

Faculty and staff must apply for medical leave under PFL, FMLA and/or DCFMLA in order to receive university-provided STML. Additionally, employees who qualify to receive a medical leave benefit under PFL will have their university-provided STML benefit payments offset in an amount equal the payment received from the District of Columbia.

Short Term Medical Leave runs concurrently with any medical leave provided pursuant to PFL, FMLA, and/or DCFMLA. In addition, PFL mandates benefit payments but not does not provide job protections, while FMLA and DCFMLA provide certain job protections.

If You Become Disabled

If you become disabled due to a non-occupational illness or injury or are to have surgery or another medical procedure that will keep you out of the office for ten or more work days, you need to call Prudential's telephonic claim intake number to start your claim. Please visit the [Leave Benefits page](#) for Prudential's contact information as well as information concerning:

- the amount and duration of your STML benefits;
- the coordination of your STML benefits PFL, sick leave, annual leave and family and medical leave benefits (if applicable); and
- an overview of the disability application and approval process with Prudential.

The STML period, when approved, becomes effective as of the disablement date (the date you became unable to work due to the disability). Approval of an STML period is based on the information provided by you and the medical information obtained from your personal physician. Any delay in the receipt of the required information may delay the approval and payment of benefits. In addition, in all cases involving the disability of any university employee, the university reserves the right to secure and

be guided by the opinion of a physician of its choice.

Although you may have returned to work between recurring absences, one STML period will apply to any single or directly related condition. Each recurring absence will require medical certification.

If You Deliver a Child

Mothers who deliver their babies receive 6 or 8 weeks of Short Term Medical Leave to recover from childbirth, depending on the type of delivery. Short Term Medical Leave precedes Parental Leave.

How the Short Term Medical Leave Benefit Works

Your STML benefits payments are provided through the university through the regular payroll process. If eligible for medical leave under the PFL, a faculty or staff member will receive a payment directly from the District of Columbia. In addition, the university has a contract with Prudential (referred to in this section as “the STML administrator”) who adjudicates Short Term Medical Leave claims on behalf of the university.

For staff, your STML benefits will start after you complete a waiting period of 7 calendar days of continuous total disability. Faculty do not have a waiting period. You must meet the conditions for receiving a benefit. In general, you will meet these conditions if you are certified by the STML administrator as being totally disabled (see below).

Definition of Disability

To qualify for STML benefits, you must meet the conditions established by the STML administrator for total disability. The STML administrator has the right to require that you be examined at its request as often as necessary to confirm your initial or continuing eligibility for plan benefits. For plan purposes, you are considered to be totally disabled if you suffer a sickness or injury that requires the regular care and attendance of a doctor, and you are unable to perform each of the material duties of your regular job.

The STML administrator has the right to investigate your claim for STML benefits at any time. At reasonable intervals, the STML administrator may ask that you be examined to determine your initial or continuing eligibility for benefits. This examination will be made at the STML administrator’s expense.

Failure to attend an examination or to cooperate with the examiner may result in the suspension or cancellation of your STML benefits.

How STML Benefits Work for Staff

If you are a staff member, the university will make no payments other than accrued sick leave, accrued annual leave, or leave share donations during the first 7 calendar days (5 work days) of any disabling condition. If your accumulated sick and annual leave total is less than 7 calendar days, you will be placed on leave without pay for the portion of the 14 calendar day waiting period for which you have insufficient leave to cover your absence. You also may receive a leave donation under the university leave sharing policy (see the [Leave Share information included in the Staff Personnel Policies Manual](#)). You continue to accrue leave when your sick and annual leave are used to cover your disability period, but you do not accrue leave when you are receiving disability payments.

After the appropriate waiting period has been met and your STML has been approved by the STML

administrator, you will receive payments equal to 100 percent of your base salary for the first thirteen (13) weeks of STML and 75% for a period for not to exceed a total of six months from the first day of disablement. These payments are made through the regular payroll process. Short term disability benefits for exempt level staff members hired prior to July 1, 1975, coordinate with the differing sick leave policy for those individuals.

Staff who qualify to receive a medical leave benefit under PFL will have their university- provided STML benefit payments offset in an amount equal the payment received from the District of Columbia.

How Short Term Medical Benefits Work for Faculty

If you are a full-time faculty member and are approved for STML by the STML administrator, your salary will continue at 100 percent for the period the first 13 weeks of approved STML and 75% for a period not to exceed 26 weeks. If your STML falls into a new full-time contract period, your STML payments will be made by the university at the previously contracted (prior year's contract) full-time annual rate, payable on a monthly basis, regardless of the payment schedule previously arranged under the prior contract. Any payments shall be refunded to the university if LTD benefits become effective for an overlapping period.

In addition, if you have already provided five years of full-time service at the onset of a disablement, and have not pre-contracted for any additional university summer income (part-time or overload summer income), you will be entitled to a payment equivalent to one-sixth (1/6) of your base annual salary in effect at the time of disablement. The payment will be divided equally among the summer months of expected disablement subject to termination dates as delineated above.

The "five years of full-time service" will be interpreted to mean that you have been compensated by or through the university (or have had some other sponsored research arrangement approved by the Provost) for at least one-twelfth (1/12) of base annual salary during at least five summers (in addition to having a full-time faculty contract).

Faculty who qualify to receive a medical leave benefit under PFL will have their university- provided STML benefit payments offset in an amount equal the payment received from the District of Columbia.

Continuation of Short Term Medical Leave Plan Payments

Your Short Term Medical Leave Plan payments will continue until the earliest of the following events:

- 26 weeks from disablement date;
- actual return to active service;
- certification by physician of ability to return to active service; or
- notification by Prudential of LTD benefits commencement.

If you are enrolled in the Prudential Long Term Disability benefits plan (LTD), and continue to be disabled after exhausting all Short Term Medical Leave benefits, you may receive additional monthly income (see [Section 5.4 Long Term Disability Benefits](#)).

If you have applied for LTD benefits but are not yet receiving them and you have exhausted the Short Term Medical Leave benefits, you will be placed on leave without pay pending determination of your LTD application or commencement of benefit payments (see [Replacement of Employees on Approved Short Term Medical Leave](#)).

Maximum Benefit Period

The maximum benefit period under the Short Term Medical Leave is 26 weeks from the disablement date.

If You Become Disabled Again

If you recover from your disability and return to work to your regular job for 60 consecutive days or less, and become totally disabled from the same or related causes, your successive period of disability will be considered one period of disability. This means that your STML Plan payments may be immediately resumed.

If you are a staff member and return to your regular job for more than 60 consecutive days and become totally disabled from the same or related causes, your STML Plan payments may be resumed after you have completed a new 14 calendar day waiting period. Faculty do not have a waiting period.

Separation from Service

The university cannot separate an individual who is on approved STML or who has initiated an interactive process under the ADAAA in which they are requesting a reasonable accommodation under the Act. With the exception of tenured faculty members, separation from employment will occur on the latter of the following:

- conclusion of the interactive process;
- effective date of commencement of LTD benefits; or
- date of denial of LTD benefits.

Tenured faculty will be placed on total disability leave as of the date LTD benefits commence.

Replacement of Employees on Approved STML

Departments are permitted to replace a faculty or staff member who is on approved STML on a temporary basis only. Lapsed departmental salary shall be used to cover the temporary replacement and the STML benefits as provided by policy. Normal budgetary channels should be followed to determine funding requirements.

If you have applied for LTD benefits but are not yet receiving them and you have exhausted the STML benefits, you will be placed on leave without pay (LWOP) pending determination of your LTD application or commencement of benefit payments. The department may fill the position when this LWOP commences. The university, while it cannot guarantee a position for an individual returning from LWOP, will make every effort to re-employ the individual in a comparable position, once the individual is certified as able to return to work.

5.4 Long Term Disability Benefits

The Long Term Disability (LTD) Plan provides you with a continuing source of income if you become totally disabled. You become eligible for LTD Plan coverage following your completion of one year of full-time service with the university.

Participation in the LTD Plan is mandatory for all eligible faculty and staff members. The cost of this

coverage is shared between you and the university.

How the LTD Plan Works

Your LTD Plan benefits are provided through a group benefit contract between the university and Prudential (referred to in this section as “the insurance company”).

Your LTD Plan benefits will start after you complete an elimination period of 180 days of continuous total disability, provided that you meet the conditions for receiving a benefit. In general, you will meet these conditions if you are certified by the insurance company as being totally disabled (see below).

Definition of Disability

To qualify for LTD Plan benefits, you must meet the conditions established by the insurance company for total disability. The insurance company has the right to require that you be examined at its request as often as necessary to confirm your initial or continuing eligibility for plan benefits.

For plan purposes, you are considered to be totally disabled if you suffer a sickness or injury that requires the regular care and attendance of a doctor and you are complying with such care, and during the elimination period and during the next 24 months of disability:

- you are unable to earn more than 80 percent of your pre-disability earnings for the university or any other employer in the local economy; and
- you are unable to perform each of the material duties of your regular job; and
- after 24 months of benefit payments you are unable to earn more than 80 percent of your pre-disability earnings at any occupation; and
- you are unable to perform the duties of any gainful occupation for which you are reasonably qualified (based on your training, education, and experience).

*Your “pre-disability earnings” means your basic monthly earnings on your last date of active work before your disability began.

The insurance company has the right to investigate your claim for LTD Plan benefits at any time. At reasonable intervals, the insurance company may ask that you be examined to determine your initial or continuing eligibility for benefits. This examination will be made at the insurance company’s expense.

Failure to attend an examination or to cooperate with the examiner may result in the suspension or cancellation of your LTD Plan benefits.

Pre-existing Conditions

The plan does not cover disabilities resulting from a pre-existing condition. A pre-existing condition is a sickness or injury for which you have received the following during the 30-day period immediately before your LTD Plan coverage began:

- medical consultation; or
- medical treatment, care, or services (including diagnostic tests); or
- prescribed drugs or medications.

The pre-existing condition provision will not apply if your total disability begins after you have performed the material duties of your job for five or more consecutive days while insured.

Please contact the Benefits Team in the Office of Human Resources with any questions about this Preexisting Conditions clause.

Continuation of LTD Plan Payments

Your LTD Plan payments will continue until the earliest of the following events:

- the date that you cease to be totally disabled, as defined by the plan (see Definition of Disability); or
- you reach the maximum benefit period (see below); or
- your death occurs.

Maximum Benefit Period

If you become disabled before age 60, your LTD Plan benefits will continue until the later of 1) the date you reach age 65 or 2) the date you reach your Social Security Normal Retirement Age. Your Social Security Normal Retirement Age is determined by your year of birth, as shown in the following table:

Social Security Normal Retirement Age	
Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

If you become disabled at age 60 or later, your LTD Plan benefits will continue until the earlier of the date you reach age 70; or 2) the date you have received 60 months of benefit payments.

Regardless of your age at the time you become disabled, your eligibility for benefits will never be less than 12 months, provided that your disability is continuous.

Mental Illness Limitation

If you are totally disabled due to a mental illness and you are confined in a hospital or other institution, your LTD Plan benefits will continue until the end of the maximum benefit period described in

Continuation of LTD Plan Payments: Maximum Benefit Period.

If you are totally disabled due to a mental illness and you are not confined in a hospital or other institution, your LTD Plan benefits will continue until the earlier of:

- 24 months; or
- the end of the maximum benefit period described in Continuation of LTD Plan Payments: Maximum Benefit Period. For plan purposes, “mental illness” means a mental, emotional, or nervous condition. Note that this limitation does not apply to certain specified conditions such as schizophrenia, dementia, and spinal tumors. Contact the Benefits Team in the Office of Human Resources or Prudential for more information.

How Your LTD Plan Benefit is Determined

If you are disabled and not working, the LTD Plan assures that your total monthly disability income (including income from the other sources listed below) equals 60 percent of your basic monthly earnings at the time you became disabled. (See [LTD Plan Benefits: If You Are Disabled and Working](#)) for more information concerning the benefits payable if you are disabled and working.

Basic Monthly Earnings

For LTD Plan purposes, your basic monthly earnings are your basic monthly salary only. Basic monthly earnings do not include overtime, commissions, bonuses, stipends, or any additional forms of compensation.

Minimum and Maximum Benefits

The minimum monthly benefit payable from the LTD Plan is \$100. The maximum combined monthly benefit payable from the LTD plan and all other sources is \$20,000.

Income from Other Sources

If you are disabled, you may be eligible to receive benefits from a number of sources. The LTD Plan will take your income from these sources into account when your benefits are determined:

- disability benefits that you receive (or are eligible to receive) under any group insurance plan or individual disability policy sponsored by the university or any governmental retirement;
- the amount of any disability income benefits which you receive or for which you are eligible under any compulsory benefit act or law, Workers’ Compensation, occupational disease law, or any other similar law; and
- primary or family Social Security benefits;

LTD Plan Benefits: If You Are Not Working

When your LTD Plan benefits are calculated, your monthly income from the other sources listed above will be taken into account. If you are disabled and not working, this will provide you with a total monthly disability income equal to 60 percent of your basic monthly earnings, up to \$20,000 per month.

Social Security Benefits

The plan will take into account any Social Security benefits that you, your spouse, or your children are entitled to receive. This includes Social Security disability and old age (normal retirement) benefits.

If you are not receiving Social Security benefits, the insurance company will make an estimate of your Social Security benefits and reduce your monthly plan benefit by that amount. This reduction will go into effect after your first three months of benefit payments.

If you are not receiving Social Security benefits, you may elect to have no reductions for these benefits applied during your first 24 months of LTD Plan benefit payments. This applies only if you provide the insurance company with the following before you have received the first six months of plan payments:

- proof that you have applied for Social Security benefits; and
- your signature on the agreement referred to below.

To qualify for the above 24-month exemption, you must sign an agreement with the insurance company. This agreement confirms that you will repay any overpayments and that you authorize the insurance company to obtain any applicable information directly from the Social Security Administration.

If you do not receive approval or final denial of your claim from the Social Security Administration by the end of the 24-month period discussed above, the insurance company will begin reducing your monthly LTD Plan benefit payments by an estimate of your Social Security benefits. (For this purpose, final denial of your claim means that you have received a Notice of Denial of Benefits from an administrative law judge.)

When you receive approval or final denial of your claim from the Social Security Administration:

- your monthly LTD Plan benefit will be adjusted; and
- you must promptly refund any overpayments to the insurance company (if you do not make this refund, the overpayments may be reduced, or used to offset any future benefits from the plan).

Other Disability Benefits

Certain sources of income will not be taken into account when your LTD Plan benefits are determined. In other words, your LTD Plan benefits will not be reduced by:

- cost-of-living increases under Social Security; or
- cost-of-living increases under one of the other income sources.

Cost-Of-Living Adjustment

A cost-of-living adjustment will be determined on the first day of the month following 18 months of continuous disability. You will also be eligible for additional adjustments on each anniversary of the first adjustment, provided that you are continuously receiving disability benefits under the plan. The total number of adjustments will not exceed five.

Amount of Adjustment

The cost-of-living adjustment is calculated by multiplying your net monthly benefit by the lesser of half of the annual percentage change in the Consumer Price Index for the prior calendar year or 6 percent.

The amount of each adjustment will be added to your net monthly benefit and will be paid monthly.

The cost-of-living adjustment does not count towards the maximum monthly benefit described in [LTD Plan Benefits: If You Are Disabled and Working](#).

Overpayment or Underpayment of Claims

After you have received one or more LTD Plan payments, the insurance company may determine that the amount of the benefits or payments from the other sources that should have been considered in computing your benefit is greater or less than what was actually considered. This may result in a payment to you if the insurance company determines that your benefits have been underpaid. If your benefits have been overpaid, the insurance company may ask you for payment, or reduce or eliminate your future payments.

Your LTD Plan Benefit: An Example

Assume that you become totally disabled and your basic monthly earnings at the time you become disabled is \$4,000 per month. Also assume that:

- you are not working; and
- you are not eligible for disability benefits from any other source.

In the above example, the LTD Plan would pay you a disability benefit of \$2,400 per month (60% x \$4,000 = \$2,400).

Now, assume that the same facts apply, except that you are entitled to a Primary Social Security disability benefit of \$1,000 per month. Your LTD Plan benefit would be determined as follows:

60 percent of \$4,000	=	\$2,400
less Primary Social Security Disability Benefit	=	(\$1,000)*
Amount paid by LTD plan		\$1,400

In this case, you would receive a \$1,400 monthly benefit from the LTD plan, and a \$1,000 monthly benefit from Social Security (total monthly benefit: \$2,400). This \$2,400 monthly benefit equals 60 percent of your basic monthly earnings at the time you became disabled.

*See [Social Security Benefits](#) for more information about the plan offsets for Social Security disability and old age benefits.

Long Term Disability Contributions to Your Retirement Plan

If you are covered under the LTD Plan and are participating in the Retirement Plan at the time you become disabled, the LTD Plan insurer will continue contributions to the Retirement Plan at the same percent of compensation level you were contributing to the Retirement Plan at that time (up to 5 percent employee deferral and 10 percent university matching contribution). Compensation is determined as of your last day of active work before the disability began.

For example, if you were making a 3 percent deferral and receiving the University matching contribution of 6 percent, the disability plan insurer would contribute 9 percent of your compensation (as of the time

you became disabled) to the Plan on your behalf. These contributions would continue until you begin to receive distributions from the Plan. These contributions will be made regardless of whether you are in a TIAA annuity, or CREF Mutual Funds or Fidelity custodial accounts.

LTD Plan Benefits: If You Are Disabled and Working

You may continue to receive an LTD Plan benefit if you are totally disabled under the terms of the plan but are earning income through any gainful work or service (including rehabilitative employment). For plan purposes, you are considered to be in rehabilitative employment if you are unable to perform all of the material duties of your regular job but are performing:

- at least one of the material duties of your regular job on a part-time or full-time basis; or
- the duties of any other gainful work or service for which you are reasonably qualified by training, education, and experience.

Amount of Benefit

If you are totally disabled but are earning income through any gainful work or service (including rehabilitative employment):

- you will receive up to 100 percent of your predisability earnings the first 24 months of LTD Plan payments without any reduction; and
- after the first 24 months, your LTD Plan payments will be reduced by 50 percent of any income that you earn (including income from rehabilitative employment).

The insurance company has the right to require that you submit evidence of your earnings and total disability at any time.

You can contact Prudential at if you have any questions concerning the calculation of your LTD Plan benefits if you are earning income while disabled.

Return to Active Status for Tenured Faculty Members

Before a faculty member with tenure who has been on Long Term Disability leave returns to active status, statements by the faculty member's physician certifying their ability to return to active status and to fulfill the responsibilities of faculty members, as defined and described in the [Faculty Manual](#), must be received. The faculty member also may provide statements from other appropriate individuals (including, for example, representatives of Prudential, the Social Security Administration, and regulatory agencies dealing with the disabled).

The provost and dean of academic affairs reserves the right to secure a second opinion within one month of receipt of the first opinion from a physician of their choice as to the ability of the person to return to active status. The decision of an independent rehabilitative agency like Social Security Administration, Prudential, or Veteran's Administration regarding the person's ability to return to active status may constitute the second opinion. Both the faculty members and the university will cooperate fully with these rehabilitative agencies so that the faculty member with a disability who has completed vocational rehabilitation may make a successful return to active status. In the case of differing opinions, a third physician chosen by the other two physicians, and paid for by the university, will be consulted.

If You Become Disabled Again

If you recover from your disability, return to your regular job on a full-time basis, and again become totally disabled, your LTD Plan payments may be immediately resumed, provided that the disability occurs within 180 days of the date that you returned to work.

If you return to your regular job for more than six consecutive months and again become totally disabled, your LTD Plan payments may be resumed after you have completed a new 180-day elimination period of total disability (see [How the LTD Plan Works](#)).

The above recurrent disability benefit provisions will not apply if you become covered by any other LTD Plan that is sponsored by another employer.

Early Intervention Program

The insurance company sponsors an early intervention program for covered individuals who may benefit from a course of disability management, with rehabilitation as the ultimate goal.

Participation in the early intervention program is completely voluntary. Your LTD Plan benefits will not be affected if you do not elect to participate in this program.

How the Program Works

Candidates for participation in the early intervention program will be identified during their first six months of total disability. You may be offered the opportunity to participate in this program if you suffer a disability which (in the judgment of the insurance company) may benefit from disability management and has the prospect of rehabilitation.

If you are selected for early intervention (and elect to participate in the program), you will be assigned a disability coordinator. Your coordinator will:

- develop a proposed disability management schedule for you;
- work with you and your attending physician to confirm the proposed disability management schedule; and
- monitor your progress towards rehabilitation.

If your attending physician agrees to the proposed disability management schedule, the insurance company may pay for specific rehabilitation, vocational, and other approved medical services listed in the schedule. (To qualify for payment, these services must not be payable under any other plan or government program.)

The insurance company has the right to terminate your participation in the early intervention program at any time. If you have any questions concerning this program, you can contact Prudential directly.

Survivor Benefit

A benefit will be payable to your surviving spouse if your death occurs after you become eligible for or start receiving LTD Plan payments. If your spouse is not living, this benefit will be divided equally between your surviving children. No death benefits will be paid if you do not have a surviving spouse or any surviving children.

Amount of Benefit

The survivor benefit is equal to six times your last monthly benefit, without any reductions for income from other sources (see [Income from Other Sources](#)), or rehabilitation earnings (see [LTD Plan Benefits: If You Are Disabled and Working](#)).

Certain Disabilities Are Not Covered

The LTD Plan does not cover disabilities which result from the following causes:

- war, insurrection, or rebellion;
- active participation in a riot;
- intentionally self-inflicted injuries, or attempted suicide; or
- the commission of or attempt to commit a felony.

5.5 Filing Your Claim

If you are absent from work due to a non-occupational illness, injury, or pregnancy, you must notify your supervisor of the absence. You must also report your absence for Short Term Medical Leave (STML) by calling Prudential. Contact information can be found on the Disability Leave page on www.american.edu/hr/benefits.

Disability claims must be resolved, at the initial level, within 45 days of receipt of the claim from the plan. The plan can extend the decision making period for an additional 30 days, if an extension is necessary for reasons beyond the control of the plan, and the plan notifies you prior to the end of the 45-day period the reasons for the extension and the time frame for when a decision may be reached. If the plan administrator determines that a decision cannot be made within the extension period, the period for making the determination may be extended an additional 30 days. This will only be the case if information is provided to you before the end of the first 30-day period.

You will be notified of any additional information that you should provide in order to resolve your claim, or of any other issue that may prevent the decision from being made. If this is the case you will be provided with at least 45 days within which to provide the specified information.

Proof of Claim

Following its receipt of your completed LTD Plan claim form, the insurance company also may require that you submit proof of your claim. If the insurance company does not furnish you with the appropriate proof of claim forms within 15 days, you may submit your own written proof no later than 90 days after the end of the six-month elimination period (see [How the LTD Plan Works](#)).

The insurance company has the right to require that you be examined by a doctor of its own choice while a claim is pending.

Denied Claims

If all or a portion of your claim for LTD Plan benefits is denied, you will be notified, in writing, of the denial as well as the specific reasons for it. The notice of denial will include the following information:

- the specific reasons for the denial;

- reference to the plan provisions on which the denial is based;
- a description of additional information required for the claim; and
- an explanation of the procedure for appeal, the applicable time limits and your right to bring a civil action under section 502(a) of ERISA.

You or someone acting for you may appeal a denial of benefits for any claim or portion of a claim within 60 days of the denial. The appeal should be in writing and include:

- a copy of the correspondence denying your claim;
- a statement of why you feel the decision is incorrect; and
- documentation supporting your statement (citing plan provisions where appropriate). All appeals requests should be sent to:

The Prudential Insurance Company of America
P.O. Box 13480
Philadelphia, PA 19176

You or your authorized representative has the right to review documents pertinent to the denied claim.

The insurance company will reevaluate all of the information pertinent to your claim. You will be notified of the plan's benefit determination on review, within a reasonable period of time, but not later than 45 days after receipt of your request for review by the plan. If the plan administrator determines that special circumstances require an extension of time, you will receive notice prior to the end of the 45-day period. In all cases, you will receive a written notification of the insurance company's final decision. This notification will explain the reasons for the decision, as well as references to the plan provisions upon which the decision was based.

5.6 End of Coverage and Continuation Options

When Your Coverage for Disability Ends

Your university-sponsored STML Plan and LTD Plan coverage will end on:

- the date that you leave full-time employment with the university, or cease to be actively-at-work and are not disabled on that date (see [*When Long Term Disability \(LTD\) Plan Coverage Begins*](#)); or
- the date that your employment classification changes to a classification that is not covered by the plan; or
- the date that a specific university-sponsored disability benefit plan is discontinued if it is the only disability coverage of that type that you are receiving; or
- for the LTD Plan, the last day of any period for which you fail to make the required contribution towards the cost of your coverage; or
- the date that the university's benefit program is terminated.

The Plan Administration section contains additional important information about your Long term Disability Plan benefits, including your rights as a participant under ERISA (the Employee Retirement Income Security Act).

6.0 Flexible Spending Accounts

For details regarding the American University flexible spending accounts (FSAs), see the [Summary Plan Description for the American University Cafeteria Plan Health Flexible Spending Account and Dependent Care Flexible Spending Account](#).

7.0 Retirement Plan

For details regarding the American University 403(b) Retirement Plan, see the [Summary Plan Description for the American University Defined Contribution Retirement Plan](#).

8.0 Education Benefits

8.1 Introduction

Eligible faculty and staff members of American University are provided with a comprehensive education benefits program. This includes tuition remission for eligible faculty and staff members and their spouse or domestic partner, as well as tuition benefits for eligible dependent children.

Under current government regulations, the education benefits program is not considered to be a covered plan under ERISA (the Employee Retirement Income Security Act). The education benefits program is therefore not subject to ERISA's participation, vesting, disclosure, or other qualification requirements.

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided, the eligibility rules, or any other feature of the plan. Your participation in the university's benefit program does not guarantee your employment with the university for any length of time.

8.2 Eligibility and Participation

The university offers you a comprehensive education benefits program, including:

- tuition remission for courses that you, your legal spouse, or domestic partner takes at American University or the Wesley Theological Seminary;
- education benefits for your eligible dependent children.

Eligibility: For You and Your Spouse or Domestic Partner

You and your legal spouse or domestic partner are eligible for university-sponsored education benefits if:

- you have at least four months of full-time employment with the university prior to the first day of classes; and
- you are a full-time faculty member; or
- you are a regular, full-time staff member.

You are not eligible for education benefits if you are working part-time or on a temporary basis. If you are not certain about your eligibility for participation, please contact the Benefits Team in the Office of Human Resources.

Full-Time Faculty Member

You are considered to be a full-time faculty member if you currently have a contract as a full-time faculty member and are receiving remuneration; or you have a nine-month contract, are receiving remuneration, and have been appointed for the upcoming fall semester.

Regular, Full-Time Staff Member

You are considered to be a regular, full-time staff member if:

- your position is classified as full time, and
- you are scheduled to work for at least 28 hours per week.

Legal Spouse

For plan purposes, the term “spouse” refers to the legal spouse of the employee. Common-law spouses are not eligible for coverage. Divorced or legally separated spouses are not eligible for education benefits.

Domestic Partner

For plan purposes, domestic partners are persons of the same gender who have a completed and document-supported Domestic Affidavit on file with human resources and:

- are registered as each other’s domestic partner, civil union partner, or reciprocal beneficiary with a government agency where such registration is available; and
- can certify that they:
- are at least 18 years of age and mentally competent to consent to a legally binding contract; are your sole domestic partner and intend to remain in this relationship indefinitely; share a close, personal relationship and you are both responsible for each other’s welfare;
- share the same primary residence (and have shared this residence for the past twelve months) and intend to do so indefinitely;
- are not married to anyone nor have had another domestic partner within the past twelve (12) months;
- are not related by blood closer than would bar marriage in the District of Columbia or the state they live in;
- are financially interdependent with you; and
- are able to demonstrate joint responsibility with you for each other’s common welfare and financial interdependence for a minimum of 12 months preceding the submission of the [Domestic Partner Affidavit](#).

Dependent Children

Education benefits are available for your dependent children. In order to qualify for dependent child benefits:

- you must have at least two years of continuous, full-time employment with the university as of September 30 for fall enrollment, or January 31 for spring enrollment; and
- your child must meet the eligibility requirements outlined in [Benefits for Eligible Dependent Children](#).

Definition of Dependent Children

For plan purposes, the term “eligible children” includes the children of either parent (whether the parents are married, legally separated, or divorced), adopted children, or children who are in the process of being adopted. This definition includes children who are both your financial responsibility and for whom you or your spouse has been appointed legal guardian.

Please see [Benefits for Eligible Dependent Children](#) for a more complete description of education benefits for your eligible dependent children.

Retirement, Disability, or Death

You may be eligible for education benefits if you are retired from active employment with the university or totally disabled. Benefits may also be available to your surviving spouse if your death occurs during your active employment with the university. This is explained in [Retirement, Disability, or Death](#) at the end of this chapter.

8.3 Enrollment and Registration

You can obtain the appropriate education benefit enrollment materials on the myBenefits site accessed through the myAU portal. A more complete description of the enrollment and registration guidelines for education benefits start in [Enrollment Guidelines](#).

8.4 Faculty Leaves

The university's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research leave or sabbatical leave are considered to be on full-time, active status while on leave. Therefore, your participation in the education benefits program may continue during a research or sabbatical leave.

8.5 Other Leaves

Please contact the Benefits Team in the Office of Human Resources for more information concerning your education benefits if you take leave with or without pay.

8.6 How the Program Works

This section provides a general description of the education benefits program. However, please remember that there are special rules governing the operation of the program, including enrollment, course registration, and course scheduling. An explanation of these rules is in [Enrollment Guidelines](#).

Each covered person who enrolls in a course of study under the education benefits program:

- is subject to the same rules and regulations which govern all other students of the university; and
- must have the required academic background for the desired course.

In no case may the amount of the AU educational scholarship/benefit exceed the actual tuition paid by the student. If a student's tuition is less due to the awarding of AU or external scholarships, fellowships, grants or other educational benefits, the student's award will be adjusted so it does not exceed the tuition paid by the student. Moreover, students may not receive two AU institutional scholarships concurrently.

8.7 Benefits for You and Your Spouse or Domestic Partner

The education benefits program provides tuition remission for undergraduate and graduate courses taken at American University or the Wesley Theological Seminary during any fall, spring, or summer semester. This benefit is available to:

- eligible faculty and staff members and their spouse or domestic partner;
- eligible retirees and their spouse or domestic partner (see [Retiree Benefits](#));

- eligible faculty and staff members with five or more years of service who become totally disabled during active employment (see [Total Disability or Death](#));
- the surviving spouse or domestic partner of eligible faculty and staff members with five or more years of service who die during active employment (see [Total Disability or Death](#)).

Maximum Benefit

The maximum benefit available to you, your spouse, or domestic partner is eight credits per semester. In addition, your total credits for courses taken under the program may not exceed 20 credits per academic year. The above benefit maximum is not cumulative. For example, assume that you receive tuition remission for only six credits during a given semester. This does not entitle you to take more than eight credits during the next semester.

Multiple Benefits for Employees and Spouse or Domestic Partner

In cases where a covered person is eligible for benefits under more than one category, the tuition benefit under the educational benefits program is applied first. For example, assume that you are an eligible faculty member, and your spouse has been selected to receive a university fellowship. In this case, your spouse will receive the tuition benefit under the educational benefits program first and any remaining eligible expenses will be covered by the university fellowship.

In other words, the benefits work as follows:

- tuition benefits under the educational benefits program; then
- the tuition benefits available through university-provided financial aid such as a fellowship.

Courses Taken at Other Institutions

In general, you and your spouse or domestic partner will not qualify for tuition remission for courses taken at other institutions (i.e., other than American University). The only exception to this rule is:

- if you are an eligible faculty or staff member; and
- you are a doctoral degree student; and
- you are required to take a course that is not offered by American University; and
- the dean of your school or college verifies that the course is required and not offered by the university.

Only in the above case may you be eligible for tuition remission. Contact the Benefits Team in the Office of Human Resources for more information.

8.8 Summary of Benefits for Eligible Dependent Children

In order to qualify for dependent child benefits, you must have at least two years of continuous, full-time employment with the university as of September 30 for fall enrollment or January 31 for spring enrollment. Your child must also meet the eligibility requirements listed in [Section 8.2: Eligibility and Participation](#).

The Education Benefits Program provides the following for eligible dependent children:

- AU tuition scholarship for full-time enrollment with regular or provisional status in a degree

- program at American University or the Wesley Theological Seminary;
- tuition at another institution which participates in the Tuition Exchange, Inc., program; or
- cash grants (available only if you were hired before and worked continuously since July 1, 1995).

See [Benefits for Eligible Dependent Children](#) for a more complete description of the above benefits, as well as the benefits available to the children of deceased, retired, or disabled faculty or staff members.

Multiple Benefits for Eligible Dependent Children

In cases where a covered person is eligible for benefits under more than one category, the maximum benefit available is the benefit for one category only. In cases where two or more members of the same family unit are employed by the university, the maximum benefit available for each dependent child is the same benefit that would have been provided if only one person were employed by the university.

For example, assume that you and your spouse are eligible employees. In this case, your dependent child may not receive double tuition benefits nor may your child combine remitted tuition with some financial aid awards, such as fellowships.

Certain Courses Are Not Covered

The education benefits program does not apply to coursework taken at mini-sessions, inter-sessions, or other special sessions. The education benefits programs do not apply to coursework taken within Instructional Revenue Centers and Online Partnership Programs. Coursework associated with online programs offered in partnership with our external partners, is not eligible for tuition remission, due to the specific terms of AU's contractual agreement with the online program providers. You may view the list of institute programs that are not covered on the myBenefits site accessed through the myAU portal.

The education benefits may not be used to maintain matriculation.

Summer Studies

During the summer semester, tuition remission may only be applied to classes assigned to the academic program in which they are enrolled. For example, a student enrolled in a graduate program can't sign up for an undergraduate course in the summer, including (but not limited to):

- internships or co-ops;
- independent reading;
- independent study courses.

The university reserves the right to limit education benefits for all summer courses on the basis of space available.

Certain Fees Are Not Covered

The education benefits program does not cover the following kinds of fees:

- application fees;
- comprehensive examination fees;
- matriculation fees;
- course fees or other charges which exceed the standard tuition rate, as defined in the course

catalogue of tuition and fees;

- Education Benefits administrative fee.

If you have any questions about the education benefit program's covered benefits or fees, please contact the Benefits Team in the Office of Human Resources.

Tax Considerations

Undergraduate tuition remission benefits for both employees and spouse are not considered taxable income under IRS regulations and therefore those benefits are not taxed.

Graduate tuition remission for spouses is taxable to the employee. Graduate and undergraduate tuition benefits for domestic partners are taxable to the employee.

IRS provisions permit the exclusion for employer-provided education assistance for graduate education provided to employees to up to \$5,250 per year. University faculty and staff who are receiving tuition remission benefits at the university receive the first \$5,250 of tuition remission benefit for employees with graduate level student status on a tax-free basis each calendar year. Courses in excess of the \$5,250 limit will be subject to FICA, Federal and State income tax.

When tuition remission is deemed taxable, the value of the taxable tuition will be included as income to the employee during the semester in which the employee or spouse/domestic partner receives tuition benefits.

AU tuition scholarship benefits for dependent children at the undergraduate level are non-taxable to the employee, and taxable to the employee at the graduate level.

8.9 Enrollment Guidelines

This section discusses the enrollment guidelines for your education benefits:

- enrollment materials;
- registration fee;
- course registration;
- course scheduling.

Enrollment Materials

You can access the appropriate enrollment application for education benefits through the myAU portal or through the myBenefits site.

You must complete an online tuition remission application for each person who is eligible to receive benefits under the program (every semester for yourself and spouse or domestic partner; once per academic year for dependent children). For example, you must complete the online application for yourself and spouse or domestic partner if you plan to enroll in a covered course. You also must complete the online application for each of your eligible dependent children who are applying for benefits under the program.

Adequate time should be allowed for the review and processing of your online application. You should submit the application well in advance of the deadline.

Registration Fee

A nonrefundable registration fee of \$50 per semester is charged for each person who enrolls in courses at American University. This fee is applied for each fall, spring, and summer semester registration, regardless of the number of courses taken.

The registration fee also applies for faculty and staff members of the Wesley Theological Seminary, as well as to American University doctoral students who have been approved for a course at another university.

Course Registration

Once you have registered for your class(es) through the academic process, you must submit your online application for tuition remission via the myAU Portal in advance of first day of classes for each semester. Upon approval of your application, Human Resources will certify your eligibility for tuition remission. There are two stages of approval for your tuition remission application. Human Resources verifies that you meet the employment requirements for the program, and then Student Accounts verifies that the class(es) are eligible. The electronic form is then routed to Financial Aid where the tuition remission benefit is applied to your account.

Please note that this process may take up to two weeks and is subject to subsequent audits. For this reason, it is critical that you alert Human Resources if you change, add, or drop courses in order for your bill to be adjusted properly. Additionally, if an audit shows that a course is not actually covered, your benefits may be removed late in the semester, past the refund point. For this reason, it is important to be sure your course is covered (see [Certain Courses Are Not Covered](#) and refer to the list on the Tuition Remission Application form on the myAU Portal for more information). If you are still uncertain, please contact Human Resources at hrpayrollhelp@american.edu or by phone at (202) 885-3836.

New Hires

In order to be eligible for education benefits for a given semester, a newly hired eligible faculty or staff member must be employed at least four months prior to the first day of classes for that semester.

If you are a new hire and have completed the four-month waiting period, once you have registered for your class(es) you can apply for education benefits by completing the online application available on the myAU portal. Human resources will certify your application for eligibility (see [Course Registration](#)).

Course Scheduling

Education benefits must be used in a manner that does not interfere with the operation of the university's offices and programs. Therefore, the following guidelines will apply:

- participating faculty and staff members may not take courses during their scheduled working hours unless they are granted an exception (see below); and
- when a conflict occurs between work and a class, work will take precedence.

“Scheduled working hours” is defined by your department head, based on your unit’s mission and the requirements of your position.

Generally, courses may not be taken during scheduled working hours. Participating faculty and staff

members may be granted an exception to this rule only if they are enrolled in degree or certificate programs.

You may request an exception by completing the online Hybrid Work Agreement form, available on the myAU portal. An attestation from your academic advisor that the course is required for graduation and is not offered at another time. Both your immediate supervisor and your unit's provost/vice president must support your request.

8.10 Benefits for Eligible Dependent Children

The education benefits program provides comprehensive benefits for the dependent children of eligible faculty and staff members. Benefits are also available for the dependent children of eligible disabled, deceased, and retired faculty and staff members (see the [Retirement, Disability, or Death](#) section).

Eligibility

In order to qualify for dependent child benefits, you and your child must meet the following requirements:

- you must have at least two years of continuous, full-time employment with the university as of September 30 for fall enrollment or January 31 for spring enrollment;
- your child must qualify as a dependent under current IRS (Internal Revenue Service) regulations;
- your child must be seeking a generally recognized degree on a full-time basis at an accredited college or university within the United States or be admitted to American University on a full-time or provisional basis;
- your child must maintain a satisfactory academic record; and
- your child's undergraduate studies must have commenced before their 21st birthday.

Benefits Overview

Benefits for eligible dependent children include the following three plans:

- Plan #1: AU tuition scholarship for full-time enrollment with regular or provisional status in a degree program at American University or the Wesley Theological Seminary;
- Plan #2: tuition at another institution which participates in the Tuition Exchange, Inc. scholarship program;
- Plan #3: cash grants (available only if you were hired before July 1, 1995).

Please remember that your child will be subject to the rules and regulations governing all students at the institution in which they are enrolled.

Benefit Allowance

A dependent child's benefit allowance for any one of the above plans (or combination of the above plans) may not exceed:

- four academic years; or
- eight semesters (or 12 quarters, if applicable);

- one academic year while enrolled full time at American University with provisional status, to a maximum of four academic years total if granted regular status.

A special rule applies if only part of the allowable benefit is necessary for the completion of an eligible dependent child's bachelor's degree. In this case, the child's unused benefit allowance may be applied towards full-time study toward a recognized graduate or professional degree at American University. The maximum unused graduate study allowance for each dependent child is:

- two academic years; or
- four semesters (or six quarters, if applicable).

In cases where two or more members of the same family unit are employed by the university, the maximum benefit available for each dependent child is the same benefit that would have been provided if only one person were employed by the university.

Children who attend American University or Wesley Seminary may receive up to two summer courses in between years in which they are registered as full-time students at American University in addition to the limits listed above (see the [Plan #1: American University Tuition Scholarship: Summer Semester Benefit](#) section). This benefit does not apply to students enrolled at other institutions.

Enrollment of Dependent Children

The online application for the enrollment of eligible dependent children can be accessed through the myAU portal.

If your child will be attending an institution other than American University, arrangements for application, admission, and housing must be made with that institution directly.

Registration Fee

A nonrefundable registration fee of \$50 per semester is charged for each dependent child who enrolls in courses at American University. This fee is applied for fall, spring, and summer registration, regardless of the number of courses taken.

Amount of Benefit

The education benefits program covers all or a portion of a dependent child's tuition expenses only. You or your child are responsible for paying all non-tuition assessments and fees at American University or another institution, including room and board.

Whether or not the education benefits program will cover full tuition depends on the institution your child attends. If full tuition is not covered, you will be responsible for paying the difference.

Plan #1: American University Tuition Scholarship

An eligible dependent child may qualify for a tuition scholarship at American University or the Wesley Theological Seminary if they:

- are admitted to American University or the Wesley Theological Seminary on a full-time or provisional basis; and

meet the other eligibility requirements outlined in [Section 8.2: Eligibility and Participation](#) and [Benefits](#)

for Eligible Dependent Children. The dependent child of a faculty or staff member will be considered eligible to receive this benefit if they are admitted to American University on a full-time or provisional basis and meet the other eligibility requirements outlined in this policy. In these situations the tuition scholarship benefit will be limited to the term of the provisional status as determined by the university's admissions office, but will never exceed one academic year.

Tuition scholarship is applied only to regular, full-time tuition at American University or the Wesley Theological Seminary as defined in the university course catalogue schedule of tuition and fees for the fall and/or spring semesters only. You or your child are responsible for payment of all other assessments or fees.

Summer Semester Benefit

For summer semester study, dependent children who are receiving a tuition scholarship benefit for full-time enrollment with regular or provisional status in a degree program at American University or Wesley Theological Seminary are eligible to receive tuition scholarships for two classes during the summer semester of the academic year in which they are enrolled. The allowance of two summer courses is not cumulative. For example, assume that your child does not use the benefit during a given summer semester. It does not entitle them to take more than two courses during the following summer semester, or receive more tuition scholarship benefits during any subsequent semester than are provided by this policy. Please note that the certain courses are not covered during the summer semester (see [Summer Studies](#) for more information).

Excluded Fees and Assessments

Expenses for the following are not eligible for tuition scholarship or reimbursement:

- occasional or part-time study;
- special programs for younger children (e.g., art, music, or skills courses);
- courses taken by a child while a student is in secondary school;
- graduation, laboratory, or studio fees;
- any application, examination, or other additional fees (including those listed in [Certain Fees Are Not Covered](#), [Enrollment Guidelines: Registration Fee](#), and [Enrollment of Dependent Children: Registration Fees](#)).

Plan #2: Tuition Exchange, Inc., Scholarships

Tuition Exchange, Inc., is a nonprofit organization of colleges and universities whose purpose is to assist in the undergraduate education of faculty and staff members' children.

An eligible dependent child may receive a competitive tuition scholarship at an institution other than American University through Tuition Exchange, provided that:

- the institution is a member of the Tuition Exchange, Inc. scholarship program;
 - the child is accepted by Tuition Exchange as an eligible student; and
 - the child's application for Tuition Exchange benefits is approved and accepted by the institution.
- Tuition Exchange scholarships are not guaranteed. They are awarded on a competitive basis by the admitting institution.

How Tuition Exchange Works

Approval of benefits for an eligible dependent child is generally dependent on a debit-credit formula developed by Tuition Exchange. If a member institution's net credits or debits exceed the allowable limits defined by the Exchange, the institution may be restricted from importing or exporting eligible children until the institution's debits and credits are in balance.

Since the availability of Tuition Exchange benefits at participating institutions may vary based on the debit-credit formula, you should determine whether or not there are openings that would be of interest to you and your child before you go too far in planning for your child's education. You may do so by going to www.tuitionexchange.org and reviewing the percentage of scholarships awarded by each admitting institution.

First-time applicants must submit the online [Tuition Exchange application](#) by November 1 preceding the upcoming academic year for the Tuition Exchange program. The tuition exchange application process is separate from the application for admission process.

Returning participants DO NOT reapply each year. If your dependent already participates in the Tuition Exchange program, you do not submit applications for subsequent years. The renewal process is managed through the Tuition Exchange program's administrative site by the school your dependent is attending and by the AU Benefits Team.

Plan #3: Cash Grants

If you were hired before July 1, 1995, you may qualify for a cash grant from American University which may be applied towards an eligible dependent child's tuition at another institution. In order to qualify for a cash grant, an eligible dependent child must be:

- enrolled in an accredited college or university within the United States;
- in good standing at the institution; and
- making satisfactory progress towards a recognized degree.

Cash grants may be applied to tuition only. No more than three eligible dependent children from each family may qualify for a cash grant in any given year.

Cash grants are available only for the eligible dependent children of faculty and staff members who were hired before and have worked continuously since July 1, 1995. You are not eligible for the cash grant program if you were hired on or after July 1, 1995.

Amount of Benefit

The amount of the cash grant is \$725 per semester, \$1,450 per academic year, fall and spring semesters only.

Benefit Limitations and Adjustments

The cash grant payment may not be applied towards any expense other than tuition. In no case may the amount of this payment exceed the actual tuition charge paid by the student.

If a student's tuition is less than the cash payment authorized, the cash payment will be adjusted accordingly. This also applies if the student is awarded scholarships, fellowships, or other grants which

are applied to their tuition.

Your application for a cash grant should be completed online through the myAU portal no later than:

- August 1 for the fall semester;
- January 1 for the spring semester.

8.11 Retirement, Disability, or Death

In general, your eligibility for the education benefits program will terminate as of the end of the semester in which you leave full-time employment with the university. However, you or your eligible dependents may qualify for a limited continuation of education benefits if you are an eligible faculty or staff member whose employment ends due to death, disability, or retirement.

Total Disability or Death

You and your spouse may continue to use the education benefits program for regularly scheduled courses at American University or the Wesley Theological Seminary if:

- you are an eligible faculty or staff member;
- you have completed five or more years of continuous service with the university; and
- you become totally disabled during active employment with the university.

Similarly, if you die during active employment with the university, your surviving spouse enjoys the same benefits, provided you are an eligible faculty or staff member who has completed five or more years of continuous service with the university at the time of your death.

If you become totally disabled during active employment, your spouse or domestic partner may continue to receive the education benefits if you are an eligible faculty or staff member who has completed five or more years of continuous service with the university at the time of your disability.

If you become totally disabled or die during active employment, your eligible dependent children may also receive a limited continuation of education benefit coverage (see [*Retirement, Disability, or Death: Benefits for Eligible Dependent Children*](#)).

Definition of Total Disability

You are considered to be totally disabled if you qualify for and are receiving benefits under the terms of the American University Long Term Disability (LTD) Plan.

Retiree Benefits

You and your spouse or domestic partner may continue to use the education benefits program for regularly scheduled courses at American University or the Wesley Theological Seminary if you retire from active employment with the university, and:

- you are an eligible faculty or staff member; and
- you have a minimum of 20 years of service and your age plus service is equal to or greater than 80.

The dependent children of eligible retirees may also qualify for a limited continuation of education

benefit coverage (see below).

Benefits for Eligible Dependent Children

The following chart summarizes the continuation of education benefits in the event of an eligible faculty or staff member's death, disability, or retirement. If you have any questions concerning these benefits, please contact the Benefits Team in the Office of Human Resources.

Education Benefits in the Event of an Eligible Faculty/Staff Death, Disability, or Retirement			
Event	Eligibility Requirements	Plan #1: American University Tuition Scholarship	Plan #2 or #3 Tuition Exchange or Cash Grant
Death or Disability	Less than 5 years of service, but child currently enrolled	Benefits continue until completion of degree if child is currently enrolled	N/A
Death or Disability	At least 5 years of service but less than 15	Full benefits	N/A
Death or Disability	15 or more years of service	Full benefits	Full benefits
Retirement	At least 20 years of service, and age plus service are equal to or greater than 80	Full benefits	Full benefits

8.12 When Your Coverage Ends

Your coverage under the education benefits program will terminate on the last day of full-time employment when you leave the university for a reason other than retirement, disability, or death (see [Retirement, Disability, or Death](#)) or your current employment classification changes to a classification that is not covered by the program. Coverage will end as of the end of the semester in which your employment is terminated due to reorganization. In addition, your coverage will terminate in the event the university terminates the education benefits program or terminates its benefit program.

Reimbursement Provision

If you voluntarily leave the university or are terminated for cause while receiving tuition benefits, you must reimburse the university for a pro rata share of the tuition benefit for the semester in which you terminate.

Reemployment

A special reemployment rule applies if:

- you voluntarily terminate your full-time employment with the university; or
- your position is eliminated due to reorganization or funding termination.

In the above cases, you may be eligible for a resumption of your education benefits at the level that is appropriate for your previous full-time service if you are rehired by the university within three

years of your date of separation, provided that your employment status at rehire fulfills the eligibility requirements for the tuition remission benefit (see [*Eligibility and Participation*](#)).

9.0 Legal Benefits

9.1 Introduction

Eligible faculty and staff members of American University can participate in a Group Legal Plan offered by MetLife Legal Plans, Inc., which provides access to legal counseling and assistance on a variety of topics.

The university reserves the right to change, amend, or terminate any of its benefit plans for active or retired faculty and staff members. These changes may extend to the level of benefits provided the eligibility rules, or any other feature of the plan. Your participation in the university's benefit program does not guarantee your employment with the university for any length of time.

9.2 Group Legal Benefits Eligibility and Participation

Participation in the university's group legal plan provides you with the following benefits:

- in-office advice, counsel, and representation on a wide variety of legal matters;
- telephone legal assistance;
- paid-in-full attorney fees when you consult a network attorney on any personal legal problems that are not specifically excluded;
- the freedom to choose a non-network attorney;
- coverage for your eligible family members.

Eligibility

You are eligible to participate in the Group Legal Plan if you are:

- a full-time faculty member; or
- a regular, full-time staff member.

Full-Time Faculty Member

You are considered to be a full-time faculty member if you currently have a contract as a full-time faculty member and are receiving remuneration.

Regular, Full-Time Staff Member

You are considered to be a regular, full-time staff member if:

- your position is classified as full time; and
- you are scheduled to work for at least 28 hours per week.

You are not eligible for participation in the Group Legal Plan if you are working on a part time or temporary basis.

Coverage for Your Eligible Family Members

In addition to covering yourself, you may elect to cover your eligible family members. Your eligible family members are:

- your spouse or same or opposite-sex domestic partner;
- your unmarried dependent children up to age 26.

Coverage Levels

Coverage begins on the first of the next month if you enroll as a new hire, or on January 1 of the next year if you enroll during open enrollment.

Cost

You pay the full cost of your group legal plan coverage through after-tax payroll deductions.

How to Enroll

Plan coverage becomes effective on the date of the following:

- the first day of the month following your date of hire (if your date of hire is the first day of the month, your coverage will be effective on that day); or
- in the fall of each year, the university sponsors an open enrollment for medical, dental, flexible spending accounts, and legal benefits. If you elect coverage during the annual open enrollment period, coverage will begin January 1 of the following year.

New Faculty or Staff Members

New faculty or staff members who are eligible to participate (see [Eligibility](#)) may enroll in the group legal plan during their first 30 days of full-time employment with the university. This election will become effective on the first day of the month following your date of hire. (If your date of hire is the first day of the month, your coverage will be effective on that day.)

For example, assume that you are hired on March 16 of a given year. Your participation in the group legal plan will start on April 1, provided that you enroll on a timely basis.

If you do not enroll within 30 days of your date of hire, you will not be eligible to participate in the group legal plan for the remainder of the calendar year. You may not elect to participate in the plan until the next annual open enrollment period.

Changing or Canceling Your Coverage

Your ability to receive legal services under the Plan ends if you are no longer an eligible employee or if you choose not to enroll during future annual enrollment periods.

If you cease to be eligible to participate in the plan or your employment with the university ends, the Plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. Of course, no new matters will be covered if started after you become ineligible.

Once enrolled, you must remain in the plan through the calendar year after which you can drop coverage during open enrollment for the next plan year.

Faculty Leaves

The university's benefits program includes provisions for faculty members' research and sabbatical leaves. Faculty members who are on research leave or sabbatical leave are considered to be on full-time, active status while on leave. Therefore, your coverage will continue during your leave, as long as you continue to make the required contributions towards the cost of your benefits.

Leave of Absence/Leave without Pay

If you take a leave of absence or leave without pay, you may elect to continue your Group Legal Plan coverage at your own expense. You may also elect to cancel your coverage. In this case, you must wait for the next annual open enrollment period to re-enroll.

You can contact the Benefits Team in the Office of Human Resources for more information concerning the continuation of your coverage if you take a leave without pay.

9.3 How the Group Legal Plan Works

MetLife Legal Plans provides personal legal services for eligible university faculty and staff, their dependent children and spouse/ domestic partner. If you have any questions, please contact the Benefits Team in the Office of Human Resources.

MetLife Legal Plans services will be provided through a panel of carefully selected participating law firms. Lawyers in this network are called Plan Attorneys. The arrangements are described in detail in this summary. The actual provisions of the Plan are set out in a written document maintained by human resources. In the event of conflict with this summary, the provisions and terms of the plan document governs.

The MetLife Legal Plan can assist you in meeting your personal legal needs through three sources:

- telephone legal assistance;
- in-office network attorney benefits;
- non-network attorney benefits.

Visit legalplans.com to use MetLife Legal Plans. Once there, click on the "Members Log in" icon at the top of the page. You will be taken to a secure page that will require you to enter the last four digits of your Social Security Number and your home zip code. After you enter this information, you will jump to a page that is specific for member services. On this page you can choose among a number of options, including:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number
- Life Guide
- Self-Help Documents/Forms

Client Service Center

You may also call MetLife Legal Plans' Client Service Center at 1-800-821- 6400. Be prepared to give your Social Security Number. If you are a spouse or an eligible dependent child of an eligible person, you will need the Social Security Number of the employee through whom you are eligible. The Client Service Representative who answers your call will:

- verify your eligibility for services;
- make an initial determination of whether and to what extent your case is covered (the plan attorney will make the final determination of coverage);
- give you a case number which is similar to a claim number (you will need a new case number for each new case you have);
- give you the telephone number of the plan attorney most convenient to you; and
- answer any questions you have about the Legal Plan.

You may then call the plan attorney to schedule an appointment at a time convenient to you. (Evening and Saturday appointments are available.)

If you choose, you may select your own attorney. Also, where there are no participating law firms, you will be asked to select your own attorney. In both of these circumstances, MetLife Legal Plans will reimburse you for these non-plan attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a case number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the legal plan.

9.4 Covered Legal Service

All benefits are available to you and your spouse and dependents, unless otherwise noted. If you have detailed questions concerning the plan, please call MetLife Legal Plans' Client Service Center at 1- 800-821-6400. Be prepared to give your Social Security Number. If you are a spouse or an eligible dependent child of an eligible person, you will need the Social Security Number of the employee through whom you are eligible.

Advice and Consultation (Office Consultation and Telephone Advice)

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The plan attorney will explain your rights, point out your options and recommend a course of action. The plan attorney will identify any further coverage available under the plan, and will undertake representation if you so request. If representation is covered by the plan, you will not be charged for the plan attorney's services. If representation is recommended, but is not covered by the plan, the plan attorney will provide a written fee statement in advance. You may choose whether to retain the plan attorney at your own expense, seek outside counsel, or do nothing.

There are no restrictions on the number of times per year you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a plan attorney in order to seek advice that would allow you to undertake your own representation.

Preexisting Legal Conditions

The plan will not pay benefits for any legal matter with an attorney hired prior to the date that your coverage became effective. The plan will pay benefits for events that occurred prior to your coverage becoming effective so long as you have not yet hired an attorney. For example, if you had a minor traffic violation in December, prior to your being covered, and will take legal action after your coverage begins January 1, and you had not yet hired an attorney, you can use this plan to hire an attorney.

What Are Legal Fees

For plan purposes, the term legal fees include the attorney's charge for their time. The term "legal fees" does not cover:

- court costs;
- court reporter's fees;
- filing fees or other miscellaneous costs;
- any fees in connection with an excluded service or action (see [Exclusions](#)).

Non-Network Attorney Benefits

If you use a non-network attorney for a covered legal service, the plan will reimburse you in accordance with a set fee schedule.

9.5 Consumer Protection

Consumer Protection Matters

This service covers you as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Small Claims Assistance

This service covers counseling you on prosecuting a small claims action; helping you prepare documents; advising you on evidence, documentation and witnesses; and preparing you for trial. The service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection

This service covers counseling you over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

9.6 Debt Matters

Debt Collection Defense

This benefit provides you with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It does not include vacating a judgment; counter, cross or third party claims; bankruptcy, any action arising out of family law matters including support and post decree issues; or any matter where the creditor is affiliated with the sponsor or American University.

Identity Theft Defense

This service provides you with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides you with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with the sponsor or American University.

Personal Bankruptcy or Wage Earner Plan

This service covers you and your spouse/domestic partner in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with American University, even if you or your spouse/domestic partner chooses to reaffirm that specific debt.

Tax Audits

This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning your tax return; negotiating with the agency; advising you on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

9.7 Defense of Civil Lawsuits

Administrative Hearing Representation

This service covers you in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense

This service covers you in defense of arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense

This service covers you in the defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent.

9.8 Document Preparation

Affidavits

This service covers preparation of any affidavit in which you are the person making the statement.

Deeds

This service covers the preparation of any deed for which you are either the grantor or grantee.

Demand Letters

This service covers the preparation of letters that demand money, property or some other property interest of yours, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which you are the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Notes

This service covers the preparation of any promissory note for which you are the payer or payee.

Document Review

This service covers the review of any of your personal legal documents, such as letters, leases or purchase agreements.

9.9 Elder Law Matters

This service covers counseling you over the phone or in the office on any personal issues relating to your parents as they affect you. The service includes reviewing your parents' documents to advise you on the effect on you. The documents include Medicare or Medicaid materials, prescription plans, leases,

nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when you are either the grantor or grantee; and preparing promissory notes involving your parents when you are the payer or payee.

9.10 Family Law

Name Change

This service covers you for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement

This service covers the preparation of an agreement by you and your fiancé(e)/partner prior to your marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse/partner. Representation is provided only to you. Your fiancé(e)/partner must have separate counsel or must waive representation.

Protection from Domestic Violence

This service covers only you, not your spouse/domestic partner or dependents, as the victim of domestic violence. It provides you with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Adoption and Legitimization (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for you and your spouse/domestic partner. Legitimization of a child for you and your spouse, including reformation of a birth certificate, is also covered.

Uncontested Guardianship or Conservatorship

This service covers establishing an uncontested guardianship or conservatorship over a person and their estate when you or your spouse/domestic partner are appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, you or your spouse/domestic partner must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

9.11 Immigration

Immigration Assistance

This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping you prepare for hearings.

9.12 Personal Injury

Personal Injury (25% Network Maximum).

Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where you are the plaintiff) at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all costs.

9.13 Real Estate Matters

Boundary or Title Disputes (Primary Residence)

This service covers negotiations and litigation arising from boundary or title disputes involving your primary residence, where coverage is not available under your homeowner or title insurance policies.

Eviction and Tenant Problems (Primary Residence – Tenant Only)

This service covers you as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of security deposit.

Security Deposit Assistance (Primary Residence – Tenant Only)

This service covers counseling you as a tenant in recovering a security deposit from your residential landlord for your primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting you in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing you for the small claims trial. The service does not include the plan attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan on your primary residence.

Property Tax Assessment (Primary Residence)

This service covers you for review and advice on a property tax assessment on your primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in refinancing of or in obtaining a home equity loan on your primary residence. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, rental property or

property held for business or investment.

Sale or Purchase of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing you, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company.

The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Zoning Applications

This service provides you with the services of a lawyer to help get a zoning change or variance for your primary residence. Services include reviewing the law, reviewing the surveys, advising you, preparing applications, and preparing for and attending the hearing to change zoning.

9.14 Traffic and Criminal Matters

Juvenile Court Defense

This service covers the defense of you and your dependent child in any juvenile court matter, provided there is no conflict of interest between you and your child. In that event the service provides an attorney only for you including service for Parental Responsibility.

Traffic Ticket Defense (No DUI)

This service covers your representation in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges

This service covers you with representation in proceedings to restore your driving license.

9.15 Wills and Estate Planning

Trusts

This service covers the preparation of revocable and irrevocable living trusts for you. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

This service covers the preparation of a living will for you.

Powers of Attorney

This service covers the preparation of any power of attorney when you are granting the power.

Probate (10% Network Discount)

Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee 10% less than the plan attorney's normal fee. It is your responsibility to pay this reduced fee and all costs.

Wills and Codicils

This service covers the preparation of a simple or complex will for you. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments.

It does not include tax planning.

9.16 Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following:

- employment-related matters, including American University or statutory benefits;
- matters involving American University, MetLife® and affiliates, and plan attorneys;
- matters in which there is a conflict of interest between you and your spouse, domestic partner, or dependents in which case services are excluded for the spouse, domestic partner and dependents;
- appeals and class actions;
- farm and business matters, including rental issues when you are the landlord;
- patent, trademark and copyright matters;
- costs or fines;
- frivolous or unethical matters;
- matters for which an attorney-client relationship exists prior to you becoming eligible for plan benefits.

9.17 Administration and Funding

The Legal Service Plan is provided for and administered through a contract with MetLife Legal Plans, Inc. MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to MetLife Legal Plans, Inc.

9.18 Plan Confidentiality, Ethics and Independent Judgment

Your use of the plan and the legal services is confidential. The plan attorney will maintain strict confidentiality of the traditional lawyer-client relationship. American University will know nothing about your legal problems or the services you use under the Plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the plan.

No one will interfere with your plan attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the plan are subject to ethical rules established

by the courts for lawyers. The attorney will adhere to the rules of the plan and they will not receive any further instructions, direction or interference from anyone else connected with the plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife Legal Plans, Inc., or the law firm providing services under the plan is responsible for all services provided by their attorneys.

You should understand that the plan has no liability for the conduct of any plan attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at 1-800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan.

9.19 Other Special Rules

In addition to the coverages and exclusions listed, there are certain rules for special situations.

Please read this section carefully.

What if other coverage is available to you?

If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents?

You may need legal help with a problem involving your spouse, domestic partner, or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the plan attorney. Your dependent will not be covered under the plan.

What if you are involved in a legal dispute with another employee?

If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement?

If you are awarded attorneys' fees as a part of a court settlement, the plan must be repaid from this award to the extent that it paid the fee for your attorney.

9.20 Denial of Benefits and Appeal Procedures

Denials of Eligibility

MetLife Legal Plans verifies eligibility using information provided by American University. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact American University for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

American University Human Resources

4400 Massachusetts Avenue NW Washington, DC 20016-8054

Within 30 days, you will be provided with a written explanation.

9.21 End of Coverage and Continuation Options

This section contains additional important information concerning:

- when your coverage ends;
- continuation of benefits;
- coordination of benefits;
- other facts you should know.

When Your Coverage Ends

Your university-sponsored MetLife Legal Plan coverage will end on:

- the date that you leave full-time employment with the university if your termination date is the first day of the month (if your termination date is any other day of the month, your coverage will continue through the end of the month in which you terminate);
- the date that your employment classification changes to a classification that is not covered by the plan;
- the date that a specific university-sponsored MetLife Legal Plan is discontinued, even if it is the only legal benefit coverage that you are receiving;
- the date that the university's benefit program is terminated.

MetLife Legal Plan coverage for a family member will also end on the date that they no longer meets the definition of eligible family members (see [Eligibility](#)).

Continuation of Benefits

If your coverage ends while a covered legal matter is in process, you will continue to receive MetLife Legal Plan benefits for that matter. This applies only if the attorney was initially employed while you were covered by the plan.

Other Facts You Should Know

American University cannot be named in a lawsuit simply because it is the policyholder of the plan. In addition, the university is not subject to contingent liability or liable to assessment for any matter arising

under the plan.

The Plan Administration section of the Faculty Staff Benefits Manual contains additional important information about your MetLife Legal Plan benefits, including your rights as a participant under ERISA (the Employee Retirement Income Security Act).

10.0 Miscellaneous Benefits

As a university employee, you are eligible for the following benefits:

10.1 Long Term Care Insurance

The university is not currently offering any new long term care insurance coverage.

UNUM and John Hancock long term care policyholders will continue with those carriers and continue to pay through payroll deduction. LifeSecure policyholders will be direct billed by the insurance company. All inquiries regarding existing policies should be directed towards the appropriate issuing insurance company.

10.2 Pre-Tax Parking and Metrochek

Full-time faculty and staff who purchase on-campus parking permits may have their deductions taken out of their pay on a pre-tax basis.

Also, full-time faculty and staff who regularly use public transportation to commute to and from work may purchase Metro, VRE, or MARC fare vouchers each month through a pre-tax payroll deduction by ordering through Optum Financial.

10.3 Pet Insurance

American University full-time staff and faculty are eligible for Nationwide® pet insurance coverage to provide your pets with the care they need. Pet coverage helps with everything from minor problems such as ear infections and upset stomachs to diabetes and cancer. Some exclusions may apply. Certain coverage may be subject to pre-existing exclusion.

Nationwide offers a choice of plans. Premium rates vary based on your pet type and your state of residence. Get a free, no-obligation quote and enroll anytime during the year on the [myBenefits portal](#).

If you need to make changes to your pet insurance, such as cancellations, upgrades, or downgrades, please call Nationwide at 844-208-1108.

10.4 Group Auto and Home Insurance

Farmers Insurance is a portable, voluntary group auto and home benefit program that provides you with access to insurance coverage for your personal insurance needs. Policies available include: auto, home, landlord's rental dwelling, condo, mobile home, renters, recreational vehicle, boat, and personal excess liability ("umbrella") policies. Policies can be paid by payroll deduction or debit from your checking account. The program gives you access to special group discounts.

As your insurance policies renew at different times during the year, you may apply for group auto and home insurance at any time by calling 855-498-3697. An insurance consultant will provide you with free, no-obligation premium quotes. If you choose to switch, a consultant can help you apply for insurance while you're on the phone. It's helpful to have your current insurance policy with you when you call.

10.5 Membership in American University Recreational Sports and Fitness

Faculty and staff are eligible to use the university's state-of-the-art fitness center at a low cost for employees and their families. Payments for membership may be made through a payroll deduction.

10.6 EP Federal Credit Union (EPFCU)

American University employees are automatically eligible to join EP Federal Credit Union (EPFCU). Learn about products and services offered by EPFCU that include checking, savings, CDs, IRAs and low rate mortgage, home equity, car and personal loans. For information about EPFCU visit www.epfcu.org or call 202-318-1991.

11.0 Legally Required Benefits

11.1 Social Security (FICA)

American University participates in the Social Security program of the federal government. The cost of this program is fixed by law and is paid equally by the employee and the university.

Participation is required by law of all full-time and part-time faculty and staff members other than full-time students who work occasionally for the university, and recipients of fellowships and scholarships that do not involve the performance of services for the university.

Payments for Social Security begin as of January 1 of each year. The full percentage is applied to the amount of salary paid each pay period, and continues until earnings reach the legal base.

A faculty or staff member interested in more information about the Social Security program is advised to communicate directly with a local Social Security office.

11.2 Workers Compensation Insurance

The university, in compliance with the laws of the District of Columbia, provides for Workers' Compensation Insurance for all full-time, part-time, and volunteer employees incurring any work related injury or illness.

In the case of serious injury, Public Safety (202) 885-3636 should be called for ambulance transportation to a hospital for medical attention. For treatment of a non-emergency nature, injured employees may specify a doctor/hospital of their choice.

All job-related accidents or injuries must be reported by the injured employee's supervisor to the Office of Risk Management where the appropriate forms must be completed.

Workers' Compensation Medical Care Benefits

All medical treatment related to cure a work related injury or illness is provided without deductibles or dollar limit. American University's Workers' Compensation Insurance carrier pays all costs associated with a work related claim. If a bill is received, it should be forwarded to the appropriate insurance carrier as directed by the Office of Risk Management & Environmental Health and Safety.

Workers' Compensation Rehabilitation Benefits

If the injury or illness prevents return to the employee's usual job, the employee may receive vocational rehabilitation as directed by the insurance carrier.

Workers' Compensation Income Benefits

Employees disabled by a job-related injury or illness receive income while unable to work. Payments are currently set at two-thirds (2/3) of the employee's average, weekly pay, up to legal maximums. Payments are not made for the first three days of disability unless the employee is hospitalized or unable to work for a period of time longer than 14 days. The first three days of an occupational illness or injury must be charged against sick leave. If no sick leave is available, annual leave must be used. If neither sick nor annual leave is available, leave without pay must be used.

Additional payments will also be made if the injury or illness results in a permanent handicap. If the

injury or illness results in death, benefits will be paid to the employee's surviving dependents.

When the injured faculty or staff member is also eligible for other university disability benefits, payments will only be received from Workers' Compensation Insurance; no payments will be made from any other university disability benefits. Financial arrangements must be made with the Benefits Office, for continued contributions to other plans when an individual is not working due to a Workers' Compensation claim.

11.3 Unemployment Compensation

The university, in accordance with the laws of the District of Columbia, provides for unemployment compensation for its employees. Claimants must apply at a local unemployment office. The unemployment office makes a determination as to eligibility after evaluation of the individual's claim.

In general, to be eligible, a claimant must be unemployed through no fault of their own, registered with the D.C. Employment Service, physically able to work, and actively seeking full-time employment.

11.4 District of Columbia Paid Family Leave (DCPFL)

Enacted in February 2017, the Universal Paid Leave Act of 2016 created the Paid Family Leave (PFL) program in the District of Columbia. It provides workers of DC employees, like American University, with:

- Eight (8) weeks of parental leave to bond with a new child, including adopted and foster children;
- Six (6) weeks of family leave to care for a sick family member
- Two (2) weeks of personal medical leave

Under this program full and part-time employees can go on bonding leave after the birth of a child, placement of a child from adoption or foster care into their households, or placement of a child into their household that they legally assume and discharge parental responsibilities over.

To qualify for personal medical leave, an employee must have a serious health condition. In general a serious health condition is a physical or mental illness, injury or impairment that requires inpatient care in a hospital, or residential health care facility, or continuing treatment or supervision at home by a health care provider or other competent individual. Routine appointments like annual physical exams, eye exams and dental exams are not considered treatment for a serious health condition. In general a serious health condition under FMLA/DCFLMA will likely be a serious health condition for PFL purposes.

Faculty and staff can take leave to care for a family member who has a serious health condition (the same conditions that qualify for personal medical leave). A qualifying family member can be a biological, adopted, foster or step child (including a child of a domestic partner); a legal ward; or someone that an employee acts as parent to. It also covers medical leave for a domestic partner or spouse, grandparent or sibling.

Full and part-time faculty and staff do not have to work a certain amount of time to accrue eligibility for this benefit. However, they must have reported wages to receive benefits. If a faculty or staff member files a claim in the middle of a quarter, then none of their earnings during that time period will be reflected in their approved benefits. For example, an employee who starts working in DC and

immediately files for benefits a few days later will receive \$0 in benefits because they would not have any wage information in the PFL tax system until the end of their first completed quarter.

To apply for the PFL program benefit, employees should contact the HR and the Office of Paid Family Leave (OPFL) within the Department of Employment Services (DOES). Employees who apply for PFL benefits, receive their eligibility determinations, and benefit awards from OPFL.

This benefit coordinates with the American University Short-Term Medical Leave, Parental Leave and Family Leave programs described in this Benefits Manual. In most cases, faculty and staff must apply for leave under PFL to receive these other benefit plans. Additionally, employees who qualify to receive a parental leave benefit under PF will have their university-provided leave benefit payments payments offset in an amount equal the payment received from the District of Columbia.. In addition, PFL mandates benefit payments but not does not provide job protections, while FMLA and DCFMLA provide certain job protections.

12.0 Plan Administration & Other Important Information

12.1 Introduction

This section of your benefits handbook contains important information concerning the administration of your benefit plans. It also describes your benefit rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

If you have any questions about the administration of your benefit plans or your rights under ERISA, please contact the Benefits Team in the Office of Human Resources.

12.2 Official Terminology

University

As used in the applicable benefit summaries contained in this handbook, the terms “university” and “the university” refer to American University.

Group Welfare Plan

The following benefits are provided under the terms of the American University Group Welfare Plan:

- health care benefits (including medical and dental benefits);
- life insurance and accidental death and disability (AD&D) insurance;
- insurance benefits;
- long term disability (LTD) plan benefits;
- prepaid legal plan benefits.

The official name of the group welfare plan is American University Group Welfare Plan.

Flexible Spending Accounts

The official name of the flexible spending account program is American University Flexible Spending Account Plan.

Educational Benefits

The official name of the education benefits plan is American University Tuition Remission Plan.

Retirement Benefits/Defined Contribution Retirement Plan

The official name of the retirement plan is American University Defined Contribution Retirement Plan.

Voluntary Benefits

American University offers a number of voluntary benefits including: long term care, pet insurance, group auto insurance, group home insurance, and a vision discount plan (see [Miscellaneous Benefits Section](#)).

12.3 Plan Documents

The benefit descriptions included in this handbook summarize the official plan documents for your benefit plans. We have tried to write these descriptions in clear, understandable, and informal language. However, you should refer to the official plan documents for more information about any of your benefit plans. In the event of any conflict between the information summarized in this handbook and the official plan documents, the plan documents will govern. The official plan documents are housed in human resources.

Plan Sponsor

The official plan sponsor for all of your benefit plans is:

American University

4400 Massachusetts Avenue, NW Washington, DC 20016

Phone Number: 202-885-2591

Plan Administrator

The official plan administrator for all of your benefit plans is:

American University

4400 Massachusetts Avenue, NW Washington, DC 20016

Phone Number: 202-885-2591

Agent for Service of Legal Process

Legal process may be served on the plan administrator and the plan sponsor at:

American University

Human Resources

3201 New Mexico Avenue, NW, Suite 350 Washington, DC 20016

Phone Number: 202-885-2591

Legal process may also be served on the insurance carrier for a plan (if applicable).

Type of Plan

The Administrative Information section shows administrative information for all of your benefit plans, including the type of plan.

12.4 Plan Funding

Defined Contribution Retirement Plan

Participant (matched and unmatched) and university contributions to the Retirement Plan are invested at participants' direction in one or more funding vehicles.

The funding vehicles for the Retirement Plan:

- may include either or both annuity contracts and custodial accounts;
- are maintained by fund sponsors that are selected by the university;
- are provided for the exclusive benefit of plan participants.

Other Plans

The flexible spending account program, group legal plan, optional life insurance, accidental death & dismemberment (AD&D) insurance, long term care insurance, pet insurance, group auto insurance, and group home insurance are funded by participant contributions. Benefits under your other benefit plans are either self-insured by the university or provided through group insurance contracts between the university and the insurance companies shown in Administrative Information.

Maximum Plan Benefits

Federal regulations require that the university's benefit plans meet certain nondiscrimination tests and other qualification rules to ensure that highly compensated employees do not receive a disproportionate share of benefits.

For more information concerning the maximum benefit limitations for your Retirement Plan, please see the applicable chapter of the Benefits Manual. You can also contact the Benefits Team in the Office of Human Resources for more information concerning the maximum benefit limitations and other qualification rules for your benefit plans.

12.5 Identification Numbers and Plan Years

Employer Identification Number

The employer identification number for all of your benefit plans is 53-0196549.

Plan Numbers and Plan Years

Each of your benefit plans has been assigned a plan number. The plan numbers and plan years for all of your benefit plans are shown in Administrative Information.

12.6 Benefit Plan Continuance

Subject to compliance with applicable government regulations, the university has the sole discretion to change, amend, or terminate any of its benefit plans for active or retired employees. These changes or amendments may include the level of benefits, eligibility rules, or any other feature of a university-sponsored benefit plan or program.

In the event that a university-sponsored benefit plan is changed or terminated, you will be notified concerning how your benefits will be affected.

You should also be aware that your participation in a university-sponsored benefit plan or program does not mean that your employment with the university is guaranteed for any length of time.

For more information concerning the continuance of the Retirement Plan, please see the applicable section of this Benefits Manual.

12.7 Administrative Information

The chart on this and the next page summarizes the plan years, plan numbers, and other important administrative information concerning your benefit plans.

Administrative Information					
Plan	Plan Type	Plan Number	Insurance Company	Policy Number	Plan Year
Medical	Welfare	510	CareFirst BCBS 840 1st Street, NE Washington, DC 20065	Care First BCBS 5800033	May 1 – April 30
			Express Script (CareFirst Participants’ Prescription Provider) 1 Express Way St Louis, MO 63121	Express Scripts D2FA	
			Kaiser Permanente 2101 East Jefferson Street, Rockville, MD 20852	Kaiser 4103-0-1	
Dental	Welfare	510	Delta Dental One Delta Drive, Mechanicsburg, PA 17055	Delta Dental 03371	May 1 – April 30
Flexible Spending Accounts	Welfare	513	N/A	N/A	January 1 – December 31
Life, Accident, Insurance and Long term Disability	Welfare	510	Prudential 751 Broad Street Newark, NJ 07102	0109821	May 1 – April 30
Group Legal	Welfare	510	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH, 44114	150/0939	May 1 – April 30
Retirement	Defined Contribution	001	N/A	N/A	May 1 – April 30

12.8 Your Rights as a Plan Participant

This section summarizes the rights you have as a plan participant’s rights that ERISA guarantees.

We have tried to make this statement of your rights under ERISA clear and helpful to you. If you have any questions after reading this section, contact the Benefits Team in the Office of Human Resources.

As a participant in American University’s benefit program, you have certain rights and protections

under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following.

Receive Information about Your Plan and Benefits

You have a right to examine, without charge, at the plan's administrator's office and at other specified locations, such as worksite and union halls, all documents governing the plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual reports (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You have a right to obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts and collective bargaining agreements and copies of the latest annual reports (Form 5500 Series) and an updated summary plan description. The administrator may request a reasonable charge for the copies.

You have a right to receive a summary of the plans' annual financial reports. The plan administrator is required by law to furnish each participant with a copy of these summary annual reports.

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, spouse or dependents 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions may occur 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 exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon people who are responsible for the operation of employee benefit plans. The people who operate your plans, called "fiduciaries" of the plans, 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 pension and/or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension and/or 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 a copy of plan documents or the latest annual report from a 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 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 domestic relations order or a medical support order, you may file a suit in 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 decides who will 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 case 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 your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., 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.

12.9 Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

The following is the Joint Notice of Privacy Practices for the American University Group Welfare Plan, American University Flexible Spending Account Plan, American University Faculty and Staff Assistance Program, and American University Faculty and Staff Wellness Program.

As required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 42 USC §1320d-1329d-8 (“HIPAA”).

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Privacy.

American University (“University”) makes health care benefits available to American University employees, and retirees, and their families through the American University Welfare Group Health Benefit Plan, the American University Flexible Spending Account Plan, the Faculty and Staff Assistance Program, and the Faculty and Staff Wellness Program (“Health Plans”).

In the course of providing these benefits, the Health Plans create records regarding your participation in these programs. Additionally, the Health Plans create records regarding you and the services that you receive from them. Each of the Health Plans is required by HIPAA to protect the confidentiality

of protected health information, as that term is defined under HIPAA (referred to in this Notice and HIPAA as “Protected Health Information” or “PHI”). They also are required by HIPAA to provide you with notice of their legal duties and privacy practices concerning your Protected Health Information.

Who Will You Receive Notices From?

Where the University provides your health coverage through a health maintenance organization or through an insurance contract with a health insurance issuer you should receive notice directly from these vendors, not from the University.

With respect to those health benefits that are funded directly by the University (the “Self- Insured Plan”), the University in its capacity as a health plan is responsible for ensuring that you receive the notice of privacy practices (“Notice”). This document constitutes this Notice. The University has contracted with professional third-party health claims administrators to administer some of these programs on the University’s behalf. These third-party administrators will also follow the privacy practices described in this Notice.

This Notice only applies to your Protected Health Information that is maintained by the Self- Insured Plan. Health care providers from whom you receive services may have different policies and procedures or notices regarding the use and disclosure of your Protected Health Information created in the provider’s office, clinic, or hospital. For information about those policies and procedures you should contact your health care provider or health care facility directly.

For Participants of the Health Benefits in the Self-Insured Plan

The information below is applicable only to participants of the health benefits in the Self- Insured Plan. This Notice provides you with the following important information:

- how we may use and disclose your Protected Health Information.
- your privacy rights in your Protected Health Information.
- your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
- the person or the office to contact for further information about your Plan’s privacy practices.

How the Self-Insured Plan May Use and Disclose Your Health Information

Your Protected Health Information may be used and disclosed by the Self-Insured Plan in the following circumstances. Some of the categories include examples, but every type of use or disclosure of PHI in a category is not listed:

- **Treatment.** Treatment is the provision, coordination or management of health care and related services. For example, a Business Associate of the Plan may disclose to a treating surgeon the name of your treating primary care physician so that the surgeon may ask for your chest X-rays from the treating primary care physician.
- **Payment.** Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Self-Insured Plan (or its Business Associate) may tell a doctor whether you are

eligible for coverage or what percentage of the bill will be paid by the Plan.

- Health Care Operations. Health Care Operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management and conducting or arranging for medical review, legal services and audits. For example, the Self-Insured Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.
- To the University as the Plan Sponsor. The Self-Insured Plan also may provide the University, in its capacity as the Plan Sponsor, with summary health information so that the University can solicit premium bids from health insurers or amend, modify, or terminate its existing arrangements with claims administrators. The Self-Insured Plan may also provide the University with information on whether you are participating in a particular health plan program. In addition, the Self-Insured Plan may disclose Protected Health Information to the University for treatment, payment or health care operations and plan administration purposes as permitted under HIPAA. Note that your Plan may not use or disclose genetic information for underwriting purposes.
- Business Associates. We may disclose Protected Health Information to the business associates that we engage to provide services on our behalf if the information is necessary for such services. For example, we may use another company to audit the performance of our third-party claims administrators on our behalf. Our business associates are obligated by law, and by contract with us, to protect the privacy of your PHI and are not allowed to use or disclose any of your PHI other than as specified in our contract with them.
- As required by Law. We may disclose your Protected Health Information as required by law.
- Public Health. We may disclose your Protected Health Information to authorized public health or other public authorities for the purpose of assisting those agencies to prevent or control disease, injury, or disability.
- Health Oversight Activities. We may disclose your Protected Health Information to a health oversight agency for activities authorized by law. Oversight activities include for example investigations, inspections, audits, surveys, licensure and disciplinary actions, civil administrative and criminal procedures or actions or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.
- Lawsuits and similar proceedings. We may use and disclose your Protected Health Information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your Protected Health Information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, provided certain requirements have been satisfied.
- Law Enforcement. We may release your Protected Health Information if requested to do so by a law enforcement official:
 - regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
 - concerning a death we believe may have resulted from criminal conduct;
 - regarding criminal conduct at our institution;

- in response to a warrant, summons, court order, subpoena or similar legal process;
 - to identify or locate a suspect, material witness, fugitive or missing person;
 - in an emergency, to report a crime (including the location of the victim of the crime, or the description, identity or location of the perpetrator);
 - if you are an inmate or under the custody of a law enforcement official.
- **Serious Threat to Health or Safety.** We may use and disclose your Protected Health Information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, and subject to applicable law, we will only disclose information to a person or organization able to help prevent the threat.
 - **Military.** We may disclose your Protected Health Information if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate military command authorities.
 - **National Security.** We may disclose your Protected Health Information to federal officials for intelligence and national security activities authorized by law. We also may disclose your Protected Health Information to federal officials to protect the President, other officials or foreign heads of state, or to conduct investigations.
 - **Workers Compensation.** Your Protected Health Information may be used or disclosed to comply with laws and regulations related to Workers' Compensation and Occupational Safety and Health.
 - **Research.** We may use and disclose your Protected Health Information for research when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information has approved the research.
 - **Organ and Tissue Donation.** If you are an organ donor, we may release your Protected Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
 - **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your Protected Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary i) for the institution to provide you with health care; ii) to protect your health and safety or the health and safety of others; or iii) for the safety and security of the correctional institution.
 - **Coroners, Medical Examiners and Funeral Directors.** We may release your Protected Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Protected Health Information to funeral directors as necessary for their duties.
 - **Other Uses and Disclosures by Written Authorization.** Uses and disclosures for other purposes will be made only with your prior written authorization. For example, we will obtain your prior written authorization for uses and disclosures related to or for: 1) psychotherapy notes; 2) marketing purposes, and 3) a sale of Protected Health Information. If you give us permission to use or disclose PHI for a purpose that requires specific authorization you may revoke the authorization, in writing, at any time, except to the extent the Self-Insured Plan has acted in

reliance on such authorization.

- Your Health Information Rights. Your Individual Rights. You have the following rights regarding the Protected Health Information that the Self-Insured Plan maintains about you: 1

1 The Self-Insured Plan does not have its own staff. Accordingly, some of the activities described in sections III(A)(1) and (2) above (i.e. a limited number of the functions that are not the responsibility of the third-party claims administrator) are conducted by university personnel who are designated by the university to act on behalf of the Self- Insured Plan. The university does not have access to information in the possession of the Self-Insured Plan, except as described in this Notice.

- Confidential Communications. You have the right to request that the Self-Insured Plan communicates with you about your health and related issues in a particular manner or at a certain location. For example, you may request that we contact you at home, rather than at work. To request a type of confidential communication, you must make a written request to the contact person identified below describing the requested method of contact, or the location at which you wish to be contacted. We will accommodate reasonable requests.
- Request Restrictions. You have the right to request a restriction on our use or disclosure for Treatment, Payment, and Health Care Operations. Additionally, you have the right to request that we limit disclosure as provided in 45 CFR §164.510. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosures, you must make a written request to the contact person identified below. The request must clearly describe (a) the information you wish restricted; (b) whether you want to limit the Self-Insured Plan's use or disclosure or both; and (c) to whom you want the limits to apply.
- Inspection and Copies. You have the right to inspect and obtain a copy of the Protected Health Information maintained by the Self-Insured Plan that may be used to make decisions about you. This right does not extend to certain PHI including psychotherapy notes (if any). The Self-Insured Plan may deny your request to inspect or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted, as required by law.
- Accounting of Disclosures. You have the right to request an "accounting of disclosures." If you request such an "accounting," you will receive a list identifying certain disclosures that the Self-Insured Plan has made of your Protected Health Information. To obtain this list, you must make a request in writing to the contact person named below.
- Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as this information is kept by the Self-Insured Plan. Any amendment request to Self-Insured Plan must be made in writing to the contact person named below. You must provide us with a reason to support your request. Any request that is not made in writing will be denied. Also we may deny your request if it asks us to amend information that is (a) accurate and complete; (b) not part of the Protected Health Information kept by or for Self-Insured Plan; (c) not part of the Protected Health Information that you would be permitted to inspect and copy; or (d) not created by the Self-Insured Plan unless the individual or entity that created the information is not available to amend the information.
- Right to Get Notice of a Breach. You have the right to be notified of a breach of your unsecured

Protected Health Information when we (or a Business Associate) determine through a risk assessment that notification is required.

- Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of the Self-Insured Plan notice of privacy practices at www.american.edu/hr/benefits/medical.cfm or by contacting the person listed below. We reserve the right to amend our notice of privacy practices. Any revision or amendment will be effective for all of the records the Self-Insured Plan have created or maintained in the past and for any records we may create or maintain in the future. Any revised notices are posted at www.american.edu/hr/benefits/medical.cfm and are sent to you electronically unless you advised us in writing that you prefer to receive a paper copy. Covered faculty and staff who are on leave, retired, or receiving COBRA benefits from the University will receive a paper copy the Notice.

Note – The university, in its health plan role, does not in the ordinary course of its operations have access to Protected Health Information in the records of the claims administrators. Similarly, the university, in its health plan role, does not have access to your Protected Health Information maintained by a FSAP provider from whom you seek services. Therefore, when you are exercising the rights discussed above, we will generally ask in the first instance that you work directly with the third-party claims administrators to access those rights.

Contact Information

If you have any questions or are required by this Notice to submit a written request to exercise rights outlined in this notice, please contact:

For the Faculty and Staff Wellness Program:

Andrea Rowe
Director, Employee Wellness and Work-Life Human Resources
American University
4400 Massachusetts Avenue, N.W.
Washington, DC 20016
(202) 885-3589

For all other Health Plans:

Ann Joiner
Executive Director of Total Rewards & Service Delivery Human Resources
American University
4400 Massachusetts Avenue, N.W. Washington, D.C. 20016-8054
(202) 885-2716

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the university's Privacy Officer or with the Secretary of Health and Human Services. All complaints to the university must be in writing and submitted to:

Assistant Vice President, Risk, Safety, and Transportation Programs HIPAA Privacy Officer
Office of Finance and Treasurer American University
4400 Massachusetts Avenue, N.W.

Washington, D.C. 20016
(202) 885-2534

Be assured that you will not be penalized for filing a complaint.

13.0 Appendix

The benefits manual has been revised to reflect the benefit changes adopted by the university since the manual was published in March 1998. All changes were previously communicated to full- time faculty and staff during the annual open enrollment periods or as programs or vendors were changed. The revised manual reflects the following updates:

- The university changed its life, short term disability and long term disability carrier to CIGNA and enhanced its optional life insurance, added optional life insurance for dependents, spouses and domestic partners and added accidental death & dismemberment (AD&D) insurance. (July 1999)
- Copayment changes were made to BCBS and Kaiser medical and prescription drug plans. (January 2000, 2002, 2003 and 2006)
- A loan feature was added to the regular retirement plan. (July 2000).
- Durable medical equipment coverage was added to the CareFirst plan. (January 2001)
- The university changed its flexible spending account vendor to FlexAmerica. (January 2001)
- A three tier prescription plan under CareFirst BCBS and a two tier prescription plan under Kaiser Permanente. (January 2003)
- A revised Short Term Disability section reflecting changes, including a revision to the recurring illness clause, decrease of staff wait period to 15 days, and an increase to 100% for staff STD payments. (May 2002)
- A revised Regular Retirement Plan section reflecting changes to new 403(b) limits for employees aged 50 or older, an expansion of the Plan Rollover Provision, and the removal of the Lockup of Contributions After 4 Years of Service provision (June 2002)
- The medical plans for any faculty and staff member who retires on or after January 1, 2003 will be coordinated with Medicare Part B (January 2003)
- The Health Insurance Portability and Accountability Act (HIPAA) privacy portion went into effect April 14, 2003. The notice included in this manual was disseminated electronically to faculty and staff on April 11, 2003.
- The university increased the Medical Spending Account contribution maximum to \$6,000. (January 2004)
- The prescription plan vendor for CareFirst BlueCross BlueShield participants was changed to Express Scripts effective April 1, 2004. (January 2004)
- Effective July 1, 2004, the medical plans for faculty and staff members who retired before January 1, 2003 will be coordinated with Medicare Part B (January 2003).
- Effective beginning fall semester 2004, the maximum tuition remission benefit for employees, spouses/domestic partners changed from two courses to 8 credits per semester not to exceed a maximum of 20 credits per academic year and applies to MBA and non- MBA students (June 2004).
- Effective beginning summer semester 2005, eligible dependent children enrolled in a degree program at AU and covered under AU's remitted tuition policy may receive remitted tuition for a maximum of two classes during the summer semester (June 2004).
- The eligibility matrix for education benefits for dependent children upon a faculty and staff member's retirement was changed to be consistent with retirement provisions for faculty: require at least 20 years of service, and age plus service equals or is greater than 80. (June 2004).

- Updated to include new qualifying event under HIPAA in which a change in a dependent's eligibility status (including, but not limited to, a spouse or dependent exceeding a lifetime limit on all benefits under another employer's plan) qualifies. (May 2005)
- Effective May 1, 2005, employees may contribute to their retirement account on a pre-tax basis only. After tax contributions are no longer permitted.
- The Health Insurance Portability and Accountability Act (HIPAA) special enrollment notice was added in July 2006.
- The university added the AARP Medicare Supplement and MedicareRx plans to the list of plans available to AU Retirees on the Benefits Extension Plan effective January 1, 2007.
- Effective January 1, 2007, the BlueCross BlueShield CareFirst plan includes a \$100 in-network deductible for non-preventative care treatments.
- Effective January 1, 2008, the BlueCross BlueShield CareFirst plan includes the Open Access feature. Open Access permits employees to see in-network specialists without a referral.
- Effective January 1, 2008, Kaiser has eliminated copayments for wellness physical exams and screenings for adults and children over 5.
- Effective January 2008, the university has amended the Tuition Remission Policy on the taxation of Educational Benefits.
- Effective May 1, 2008, the university has amended the Retirement Account plans in compliance with changes in the 403(b) regulations.
- The Flexible Spending Account vendor has changed from FlexAmerica to PayFlex effective December 1, 2008.
- Effective January 1, 2009, the university has added acupuncture, chiropractic services, hearing aids, infertility, out-of-network contraceptive devices, psychological testing, transgender benefits, and travel inoculations to CareFirst and acupuncture, chiropractic services, hearing aids, infertility, to Kaiser Permanente.
- Effective January 1, 2010, the following changes were made:
 - Mental health benefits have been enhanced in both CareFirst and Kaiser – they are now equal to other medical benefits in terms of copayments and coverage.
 - Delta Dental PPO plan replaces the CareFirst and DentaQuest plans and features an expanded network and improved benefits. AU will contribute towards the cost of coverage.
 - Base life insurance is set at a full one times salary and no longer capped at \$50,000.
- Optional life insurance can be elected for coverage up to four times salary or \$600,000, whichever is lower.
- The long term disability definition of disability has been changed and the limitations updated.
- Hyatt Legal's MetLaw Plan is the new legal plan which expands coverage.
- New pet insurance, as well as a discount vision plan, and group auto and home insurance through MetLife.
- Effective January 1, 2011, the term Domestic Partner was expanded to include opposite sex domestic partners for all benefits but Educational Benefits which are limited to same-sex partners. The definition for both same and opposite sex partners is modified with a 12-month waiting period for benefits eligibility.
- Effective January 1, 2012, the following changes were made:
 - Addition of new Basic Dental feature to the Delta Dental plan, in addition to the Comprehensive Dental Plan that had been in place.

- The Express Scripts prescription drug plan was modified to a coinsurance reimbursement structure, with a limit up to the prior year's copayment.
- Kaiser Permanente has three copayment changes
- Effective January 1, 2013, the following changes were made:
 - The Express Scripts' Preferred Home Delivery program was introduced.
 - The medical flexible spending account limit was lowered from \$6,000 to \$2,500 and coverage for women's preventive health services were provided at no copay in compliance with health care reform.
- Effective January 1, 2014, the following changes were made:
 - The in-network deductible for CareFirst was increased from \$100 individual/\$200 family to \$200 individual/\$400 family.
 - The transgender benefit limit was increased to \$400,000 per lifetime.
- The university changed its life insurance carrier to Prudential effective January 1, 2016 (January 2016). The university changed its short term disability and long term disability carrier to Prudential effective March 1, 2016 (March 2016).
- In March 2019:
 - The CareFirst section was updated to reflect changes to the plans effective January 1, 2019
 - The Flexible Spending Accounts were updated to reflect the change to ConnectYourCare as administrator of the FSAs
 - The long term care was updated to reflect that the university does not currently have a long term care provider issuing new policies.
- Effective January 1, 2020, American University transitioned Medicare-eligible medical benefits to a Private Medicare Exchange provided through Mercer Marketplace 365+ RetireeSM, provided by Mercer Health & Benefits Administration, LLC.
- Effective July 1, 2020, American University:
 - Changed the waiting period for staff on Short Term Medical Leave (formerly called Short Term Disability) from two weeks to one week.
 - Eliminated the need to exhaust accrued leave beyond the one-week waiting period on Short Term Medical Leave for staff.
 - Coordinated paid leave benefits for Parental Leave, Short Term Medical Leave, and FMLA with DC Paid Family Leave.
 - Due to the financial impact of COVID-19, the university temporarily suspended employer matching contributions and automatic enrollment to the American University 403(b) Retirement Plan effective August 1, 2020, for at least 12 months.
- Effective November 2023, American University:
 - Updated the name ConnectYourCare to Optum Financial to reflect the update in company name.
 - Moved FSA summary documents online to the Benefits website.