

# **Prescription Drug Summary Plan Description**

Western Governors University

Effective: January 1, 2025

## **Prescription Drug Summary Plan Description**

Western Governors University's (the "Plan Sponsor") Prescription Drug Plan (the "Plan") is administered by CVS Caremark.

Enrollment in the Plan is automatic when you enroll in Western Governors University's medical plan. The coverage effective date and termination date of each member's prescription drug coverage is in accordance with the coverage terms established by Western Governors University's medical plan(s) provisions.

This summary plan description (SPD) outlines the provisions of the Plan in effect as of January 1, 2025. Please read the information in this SPD carefully and share it with your family. Keep this SPD in a convenient location so you can refer to it whenever necessary. You will be notified when changes are made to the benefit plans. Please keep those notifications with this SPD.

All benefits and coverages described in this summary plan description (SPD) are effective as of January 1, 2025 ~ and are subject to the terms of the plan document under which the Plan is provided.

Western Governors University reserves the right to amend any of the programs and arrangements described in this SPD (including changing the method of providing benefits and curtailing or reducing future benefits) or to terminate at any time for any reason, any or all the programs and arrangements herein described.

If there is any conflict between this SPD and the plan documents, the plan documents will always govern.

Neither this SPD nor the benefits described herein constitute a contract of employment or a guarantee of employment between Western Governors University and any employee.

Western Governors University intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw, or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

On its effective date, this SPD replaces and overrules any SPD that the Plan Sponsor may have previously issued to you. This SPD will in turn be overruled by any SPD issued to you in the future.

The Plan will take effect on January 1, 2025. Coverage under the Plan starts at 12:01 a.m. and ends at December 31, 2025 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is governed by ERISA unless the Plan Sponsor is not a private plan sponsor.

# Contents

- Prescription Drug Summary Plan Description .....2
- How the Prescription Drug Program Works .....5
  - Eligibility.....5
  - Enrolling for Coverage .....6
  - Special Enrollment Period: .....6
  - Making Changes During the Year .....7
  - Coverage While on a Leave of Absence .....8
  - General Information about When Coverage Ends .....10
- Fraud or Intentional Misrepresentation of a Material Fact .....10
- Coverage for a Disabled Dependent Child.....11
- Continuation of Coverage .....11
- Your Member Identification Card (ID) .....12
- Your Prescription Drug Coverage .....12
  - Brand and Generic Drugs .....14
  - Using a Retail Network Pharmacy.....14
  - Filling Long-Term Prescriptions.....14
  - Using a Retail Non-Network Pharmacy .....15
  - Specialty Pharmacy .....15
- Clinical Coverage Review and Drug Limitations .....16
  - Prior Authorization .....16
  - Step Therapy .....16
  - Quantity Limits .....17
  - Compound Prior Authorization .....17
  - Opioid Management Program .....17
  - Preventive Services .....17
  - Cost Saver.....18
  - What Is Covered? .....18
  - What is Not Covered?.....19
- Right of Appeal.....21
  - Other Resources.....21
- If You Are Covered by More Than One Plan .....22

Does This Plan Have the Right of Recovery? .....22

Continuation of Coverage Through COBRA .....23

    Who Is Covered under COBRA.....24

Plan Documents .....29

Your HIPAA Privacy Rights .....30

Non-Assignment of Benefits .....30

Qualified Medical Child Support Order (QMCSO).....30

Change or Termination of the Plan .....31

Employment Rights Not Implied.....31

Your Rights under ERISA.....31

    Receive Information about Your Plan and Benefits .....31

    Continue Group Prescription Drug Plan Coverage .....32

    Prudent Actions by Plan Fiduciaries.....32

    Enforce Your Rights.....32

Assistance with Your Questions .....33

## How the Prescription Drug Program Works

### Eligibility

#### Who Is Eligible for Coverage?

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as an Employee. For a complete definition of Eligible Person, Plan Sponsor and Employee, see *Section 9: Defined Terms*.

You are eligible to enroll in the Plan if you are a regular or temporary full-time employee who is scheduled to work at least 30 hours per week.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons under the Plan Sponsor's Plan, each may enroll as an Employee or be covered as an Enrolled Dependent of the other, but not both.

#### Dependent

Dependent generally refers to the Employee's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your legal spouse or registered domestic partner.
- You or your spouse's / domestic partner's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

## **Enrolling for Coverage**

### **How Do You Enroll?**

You will receive information, including instructions on how to enroll, before Open Enrollment each year.

### **Initial Enrollment Period**

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

### **Open Enrollment Period**

The Plan Sponsor sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

## **Special Enrollment Period:**

### **New Eligible Persons**

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form within 31 days of the date the new Eligible Person first becomes eligible and any required contribution on the first paycheck the month after the employee is eligible.

### **Adding New Dependents**

Employees may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event.

## **Making Changes During the Year**

### **Special Enrollment Rights**

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.
- Change in residence.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.

- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

## **How to Make Changes**

To make a change, contact Western Governors University Benefits at [Benefits@wgu.edu](mailto:Benefits@wgu.edu).

## **Coverage While on a Leave of Absence**

### **Family and Medical Leave Act (FMLA) Leave**

The federal Family and Medical Leave Act of 1993 (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty or call to active duty in the Armed Forces or a military reserve unit from the National Guard, Military Reserve or retired status in the Armed Forces or Reserve. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact Western Governors University, People & Talent at [benefits@wgu.edu](mailto:benefits@wgu.edu).

If you take an FMLA leave, you may continue your group health coverage (Medical, Dental, Vision, Employee Assistance Plan, Fertility Health Reimbursement Arrangement, Wellness Benefits, and Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by pre-paying for your coverage on a pre-tax basis, and/or catching up with pre-tax contributions upon your return from leave. For your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account Coverage, you may continue (but do not have to) your participation and have Western Governors University front the

contributions; however, the fronted contributions will be recouped upon your return. You also have the option to suspend your health coverage during the leave.

If your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account coverage terminates during your leave, you may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to “make up” for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care Flexible Spending Account coverage amount.)

Your Basic Life, Basic AD&D, Employee Assistance Plan, Wellness Benefit, Fertility Health Reimbursement Account, Short-Term Disability and Long-Term Disability coverages will continue during an FMLA leave. Your Supplemental Life, Dependent Life, Supplemental AD&D, Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance, and Voluntary Hospital Indemnity Insurance coverage will continue during FMLA leave if you continue to pay the required after-tax contributions during your leave. Your contributions to the Dependent Care Flexible Spending Account will continue during a paid and unpaid leave.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage

### **Disability Leave of Absence**

Please contact your Plan Administrator’s representative for details on how your coverage is handled and if/when your coverage ends if you take a leave of absence

### **Military Leave of Absence**

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee’s Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24-month period beginning on the date of the Employee's absence from work.
- The day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

## **General Information about When Coverage Ends**

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Employee's coverage ends.

## **Fraud or Intentional Misrepresentation of a Material Fact**

The Plan will provide at least 30 days advance required notice to the Employee that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing

incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

## Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental or physical disability.
- The Enrolled Dependent child depends mainly on the Employee for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, the Plan Sponsor may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan Sponsor's request as described above, coverage for that child will end.

## Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Plan Sponsors that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Plan Sponsor is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

## Your Member Identification Card (ID)

When you enroll in a medical plan, you will automatically receive an ID card from UHC with CVS Caremark information included. You will receive one member ID card for each member enrolled. Watch for those ID cards to arrive in December if you enroll in a WGU medical plan. You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any Copayment Amount directly to the network Pharmacy. You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.

## Your Prescription Drug Coverage

The Plan is managed by CVS Caremark and covers prescription drugs that are approved by the U.S. Food and Drug Administration (FDA). When you need to fill a prescription, you can:

- Go to a network pharmacy,
- Use the mail order delivery service, or
- Go to a non-network pharmacy.

Below is a summary of the prescription drug coverage under each medical option.

<b>Prescription Drug Plan</b>	<b>HDHP</b>
<b>Annual Plan Deductible</b> (Integrated with medical)	
Network Pharmacy:	\$2,000 Individual \$3,500 Family
Out-of-Network Pharmacy:	\$4,000 Individual \$8,000 Family
<b>Annual Out-of-Pocket Maximum</b> (Integrated with medical)	
Network Pharmacy:	\$4,000 Individual

Prescription Drug Plan	HDHP
	\$8,000 Family with \$7,000 Individual out-of-pocket maximum embedded within the family amount
Out-of-Network Pharmacy:	\$8,000 Individual \$16,000 Family
<b>Retail from a Network Pharmacy*</b> (up to 30 day supply)	Tier 1: \$10.00 Tier 2: 35% coinsurance Tier 3: 50% coinsurance
<b>Retail 90 from a Network Pharmacy*</b> (up to 90 day supply)	Tier 1: \$20.00 Tier 2: 35% coinsurance Tier 3: 50% coinsurance
<b>Mail Order Pharmacy*</b> (up to a 90 day supply)	Tier 1: \$20.00 Tier 2: 35% coinsurance Tier 3: 50% coinsurance
<b>Specialty Medications*</b> (up to 30 day supply)	Tier 1: \$10.00 Tier 2: 35% coinsurance Tier 3: 50% coinsurance
<b>Out-of-Network Pharmacy*</b> (up to 30 day supply)	Tier 1: 60% coinsurance Tier 2: 60% coinsurance Tier 3: 60% coinsurance Specialty: Not Covered

\*Member cost share only applies after the deductible has been met.

The HDHP Plan includes a “Preventive Drug List,” which is a list of long-term use medications to which the plan’s deductible does not apply.

Medical and prescription drug costs count toward a single out-of-pocket maximum. Once you reach the annual out-of-pocket maximum, you do not have to pay anything further for your covered medications for the rest of the year. There is one combined annual out-of-pocket maximum for both medical benefits and prescription drug benefits.

Your cost is based on the network-negotiated price for the drug. Prescriptions filled at non-network pharmacies are covered at the network-negotiated price minus your cost-share. You are responsible for your cost-share plus the amount beyond the network-negotiated price.

## Brand and Generic Drugs

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

If you or your provider specifically requests the brand name medication when a generic is available, you will pay the brand drug copay, plus the difference between the total cost of the brand name drug and the generic drug cost.

Preferred brand and generic drugs, also known as formulary drugs, are medications that have been reviewed and approved by a group of physicians and pharmacists and have been added to the formulary selected by the Plan based on their proven clinical and cost effectiveness.

Non-preferred brand drugs, or non-formulary drugs, are medications that the same team of physicians and pharmacists have not approved for the formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.

The formulary changes from time to time as new clinical information becomes available. To determine the status of any drug on the Plan's formulary, go to [www.caremark.com](http://www.caremark.com) or contact customer service at 833-267-8259. A medication's inclusion on the formulary is no guarantee of effectiveness. Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary.

## Using a Retail Network Pharmacy

Network pharmacies have agreed to accept lower, negotiated fees than non-network pharmacies. When you need to fill a prescription, go to a network pharmacy and present your prescription drug ID card. To find a network pharmacy near you or to see if your pharmacy is part of the network, go to [www.caremark.com](http://www.caremark.com) or contact CVS' customer service at 833-267-8259.

- Short-term prescriptions are covered through a retail pharmacy. Your retail network purchases are limited to a 90 day supply for each prescription, with the exception of medications packaged in greater than a 90 day supply.
- If a pharmacy's price is less than the coinsurance or copay you would pay for that drug, you'll pay the lower price. For example, if the actual cost of a generic medication is \$3.50, but your copay is \$10.00, you will pay \$3.50.

## Filling Long-Term Prescriptions

Some examples of long-term maintenance drugs are those used to control or treat:

- Arthritis
- High cholesterol
- Diabetic conditions, and
- High blood pressure.

### **Mail Order**

With this service, you can order up to a 90-day supply of maintenance drugs and have them delivered to your home.

In order to fill your prescription through CVS Caremark Mail Order, ask your provider to send an electronic prescription to CVS Caremark Mail Service Pharmacy; or request that CVS Caremark contact your provider and get the process started for you by calling CVS Caremark at 833-257-8259. To start online, visit [www.caremark.com](http://www.caremark.com) and select *Start Rx Delivery by Mail*.

### **Using a Retail Non-Network Pharmacy**

If you purchase your prescription drugs through a non-network pharmacy or do not show your prescription drug identification (ID) card at a network pharmacy, you will have to pay for the prescription and then file a claim form for reimbursement. The Plan will pay benefits based on the amount it would have paid to a network pharmacy. You will pay the difference between what the non-network pharmacy charges and the Plan's benefit payment.

Claim forms are available at [www.caremark.com](http://www.caremark.com). You can mail your completed claim form to the address listed on the form.

If you have any questions about filing a claim, call Member Services at 833-267-8259 or visit [www.caremark.com](http://www.caremark.com) to submit your claim online.

### **Specialty Pharmacy**

Complex conditions, such as anemia, hepatitis C, multiple sclerosis, asthma, cancers and rheumatoid arthritis, are treated with specialty medications. Specialty medications can be injectable medications administered either by you or a healthcare professional and they often require special handling. If you use specialty medications, you'll have access to the services offered by CVS Specialty Pharmacy at 1-855-299-8259 or [www.cvsspecialty.com](http://www.cvsspecialty.com). CVS Specialty Pharmacy provides not only your specialty medicines, but also personalized Pharmacy care management services including:

- Safe, prompt delivery. CVS Specialty Pharmacy will schedule and quickly ship all your specialty medications, including those that require special handling such as refrigeration.
- Personalized care. You'll have access to a team of specialty-trained pharmacists, nurses and patient-care representatives who are trained in your condition.
- Supplies. Most supplies, such as syringes, needles and sharps containers, will be provided with your medication.

- Support – 24/7. CVS Specialty's specialty-trained pharmacists and nurses are available around the clock to answer your questions. The CVS Specialty team can assist in managing side effects.
- Refill reminders. CVS Specialty will contact you regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online, safely and securely, through [www.cvsspecialty.com](http://www.cvsspecialty.com).
- Drug safety monitoring. As a CVS Caremark pharmacy, CVS Specialty pharmacy can access your prescription information on file at all CVS Caremark pharmacies to monitor for potential drug interactions and side effects of your medications.
- Online support and resources through [www.cvsspecialty.com](http://www.cvsspecialty.com) including condition-specific information and the specialty Pharmacy drug list.

### **Accumulator Adjustment Program for Specialty Medications**

The CVS Caremark True Accumulation Program disallows coupon dollars from manufacturer copay assistance programs for Specialty medications from applying to your annual accumulators (out-of-pocket maximum and deductible, if applicable).

## **Clinical Coverage Review and Drug Limitations**

### **Prior Authorization**

Some drugs may require pre-authorization. If the necessary pre-authorization is not obtained, the drug may not be covered. If a pharmacist tells you that a prescription requires pre-authorization, CVS Caremark will need to communicate with the provider to be sure that the medicine is right and will verify that the Plan covers the drug.

When a prescription requires pre-authorization, the provider can contact CVS Caremark to prescribe a different medicine that is covered by the Plan or start a pre-authorization on your behalf. Only the prescriber can give CVS Caremark the information needed to determine if the drug may be covered. If the medicine is approved, you will pay the normal copay. If the medication is not covered but you want to take it, you will pay the full price of the medicine.

### **Step Therapy**

Your plan uses utilization management programs that require you try one or more drugs before another drug will be covered.

Step Therapy is a program for people who take prescription medicine regularly to treat a long-term condition, such as arthritis, asthma or high blood pressure. It lets you get the treatment you need affordably. First-line medicines are the first step.

- First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy

suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

- Second-line medicines are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

## Quantity Limits

Quantity Limits are in place to make sure that you are getting the right amount of medication and that it is prescribed in the most efficient way. For example, your provider may say, “take two 20mg pills each morning.” If that medication is also available in 40mg pills, CVS Caremark will notify the pharmacy about contacting the prescriber for one 40mg pill a day instead of two 20mg pills. In addition, if your provider writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and you will have just one copayment, not two.

Quantity Limits also make sure that your prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact your provider to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

## Compound Prior Authorization

The Plan currently participates in CVS Caremark’s Compound Prior Authorization Program. Prior Authorization is required for compounded prescriptions that cost more than \$300.

## Opioid Management Program

CVS Caremark’s Opioid Management Program limits the quantity of opioids, requires step therapy, and is designed to (i) help improve management of opioid use; and (ii) reduce potential misuse/abuse. It is aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC). The Opioid Management Program uses the CDC criteria of Morphine Milligram Equivalent (MME) to limit the quantity of opioid products. Prior authorization requests can be made if your provider believes the dose should exceed the MME within the CDC recommendation. The Opioid Management Program is not intended to be applicable to cancer treatment or palliative end-of-life care.

## Preventive Services

The Patient Protection and Affordable Care Act (PPACA) contains a provision to make certain preventive services available without cost-sharing to the member. Any plan exclusions, formulary, or utilization management status would be overridden by the adoption of one or more of the following categories. The CVS Caremark standard drug coverage recommendations include information regarding suggested patient demographics that would be applicable to each drug therapy. The following preventative items and services are covered at no cost to you under your pharmacy plan.

- Aspirin products

- Fluoride products
- Folic acid & prenatal vitamins
- Tobacco smoking cessation products
- Immunizations
- OTC contraceptives
- Prescription contraceptives
- Contraceptive devices – diaphragms, cervical caps, IUD, implants
- Bowel prep agents for colorectal cancer screening
- Breast cancer – primary preventive
- Statins
- Pre-exposure prophylaxis (PrEP) – prevention of HIV infection

## **Cost Saver**

Your CVS Caremark benefits include Cost Saver, which is a tool that ensures that you pay the lowest prescription drug price. If there is a lower price available outside of the insurance benefit (i.e., through a discount card like GoodRx), Cost Saver applies that price and the amount you pay counts towards your annual deductible and out-of-pocket maximums. Some limitations apply; Cost Saver only applies to non-specialty generic drugs.

## **What Is Covered?**

The Plan covers most prescription drugs approved by the U.S. Food and Drug Administration (FDA) for outpatient care. The following list includes covered prescription drugs. Certain over-the-counter medications may be covered when prescribed by a physician. For the most current information on the types of drugs covered under the Plan, please visit [www.caremark.com](http://www.caremark.com) or contact CVS' customer service at 833-267-8258.

This list may change at any time:

- Federal legend drugs (other than those identified as not covered).
- State restricted drugs.
- Medications of which at least one ingredient is a legend drug (other than those identified as not covered).
- Insulin.
- Needles and syringes.

- Certain over-the-counter medications and supplies, such as diabetic supplies, fluoride, contraceptives for women, and bowel evacuants when prescribed by a physician.
- Legend and over-the-counter smoking deterrents for participants age 18 and older.
  - Get a prescription for these products from your provider, even if the products are sold over the counter (OTC).
- Oral contraceptives and devices.
- Contraceptive jellies, creams and foams if FDA-approved and prescribed by your physician.
- Emergency contraceptives.
- Immunization agents and vaccines.
- Certain self-injectables.

## **What is Not Covered?**

### **The following are excluded under your pharmacy plan:**

- Blood components (Hemophilia and HAE are not included in this category).
- Bulk chemicals.
- Cosmetic alteration drugs (e.g., Botox, Latisse, etc.)
- Diagnostic agents (unless brought in by drug coverage section).
- Digital therapies.
- General anesthetics.
- Multi-vitamins.
- Multi-vitamins with fluoride.
- Multi-vitamins with iron.
- OTC products (unless brought in by drug coverage section).
- Repackaged products.
- Surgical supply/medical devices (unless brought in by drug coverage section).
- Oral and injectable fertility medications.
- Homeopathics.
- Electrolyte replacement products.

- Nutritional supplements.
- Dietary management.

## **Right of Appeal**

### **Can I appeal this decision?**

Yes. You, your provider, or an appointed representative like an attorney or family member can file a standard (non-urgent) or urgent appeal within 180 calendar days from the date of this decision. Otherwise, this decision will be final. Urgent appeals may be submitted by phone or in writing. Standard (non-urgent) appeals may be submitted in writing by fax or mail.

Appeal requests – Mail  
Caremark, Inc.  
Appeals Department, MC 109  
P.O. Box 52084  
Phoenix, AZ 85072-2084

Appeals requests – Fax  
ATTN: Appeals Department  
866.443.1172

Specialty appeal requests – Mail  
CVS/Caremark, Inc.  
Specialty Guideline Management Appeals Department  
800 Biermann Court Ste. B.  
Mt. Prospect, IL 60056

Specialty appeals requests – Fax  
ATTN: Appeals Department  
855.230.5548

### **How long does the appeal process take?**

Standard (non-urgent) appeals can take up to 30 calendar days from when your request is received. You will receive written notice of the decision.

### **What if my appeal is urgent?**

In some cases, urgent appeals can be reviewed, and a decision could be made within 72 hours. Generally, you can request an urgent decision for these reasons:

- Life, health or ability to function would be in jeopardy based on layperson's judgement.
- You may be subject to severe pain without the treatment or care requested in the opinion of a clinician who is aware of your condition.

## **Other Resources**

You and your plan may have other ways to get help with, resolve, or dispute this decision.

### **Where can I go for more help or to file a complaint?**

U.S. Department of Labor  
Employee Benefits Security Administration  
200 Constitution Ave., NW Washington, DC 20210

(866) 4-USA-DOL (866-487-2365)  
<http://www.dol.gov/ebsa/>

### **Can I have an external review of this decision?**

A Plan member whose Claim Involving Medical Judgment or the rescission of coverage is denied may request, in writing, an External Review of such Claim within four months after receiving notice of the Final Internal Adverse Benefit Determination. The member's request should include the member's name, contact information including mailing address and daytime phone number, member ID number and a copy of the coverage denial. The member's request for External Review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark  
External Review Appeals Department, MC 109  
P.O. Box 52084  
Phoenix, AZ 85072-2084  
866.443.1172 (fax)

### **If You Are Covered by More Than One Plan**

If you or a covered dependent has coverage under the Plan and coverage under another prescription drug plan, benefits under the Plan are coordinated with those provided by the other plan so that your combined coverage doesn't exceed the provider's fees for eligible expenses.

### **Does This Plan Have the Right of Recovery?**

#### **Overpayment and Underpayment of Benefits**

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Allowed Amounts.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

## **Refund of Overpayments**

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- Equal the amount of the required refund, or
- If less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.
- The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

## **Continuation of Coverage Through COBRA**

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers sponsoring group health plans offer to employees, their spouses and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances (called "qualifying events") where coverage under the plan would otherwise end.

Eligibility to elect COBRA coverage is contingent upon your being enrolled as an active employee prior to the qualifying event.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to elect continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

Western Governors University reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the Plan.

You must pay the entire contribution (employee plus employer cost) plus a 2% administration fee for your continuation coverage. A grace period of at least 60 days applies to the payment of the regularly scheduled contribution.

**Note:** You may have options other than the COBRA continuation of health benefits available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. The day after your employment terminates and you are ineligible for coverage under the Plan, there is a 60 day special enrollment period during which you can enroll for coverage in the Health Insurance Marketplace. If you are considering enrolling for coverage under the Exchange, be mindful of this enrollment deadline.

## Who Is Covered under COBRA

You have a right to choose this continuation coverage if:

- You are enrolled in Plan; and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you terminate employment following a leave of absence qualifying under FMLA the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of (a) the date that you indicate you will not be returning to work following the leave; (b) the date that you do not return to work after the leave; or (c) the last day of the FMLA leave period.

If you are the spouse of an employee and are covered by Plan and you lose coverage for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

- The death of your spouse;
- The termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or a reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse's entitlement to Medicare.

If you are a covered dependent child of an employee who is covered by the Plan on the day before the qualifying event and you lose coverage under the Plan for any of the following five reasons, you are also a qualified beneficiary and have the right to continuation coverage:

- The death of the employee;
- The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
- The employee's divorce or legal separation;
- The employee's entitlement to Medicare; or
- You cease to be a "dependent child" under the Plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of continuation coverage the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plans and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Western Governors University of the birth or adoption.

If the covered employee fails to notify Western Governors University a timely fashion (according to the terms of the Plan), the covered employee will not be offered the option to elect COBRA coverage for the child. Newly acquired dependents (other than children born to, adopted by or placed for adoption with the employee) will not be considered qualified beneficiaries but may be added to the employee's continuation coverage.

### **Separate Elections**

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. A spouse/partner or dependent child may elect different coverage from that chosen by the employee.

### **Electing COBRA**

You will automatically receive COBRA election information from the COBRA Administrator. The date of the qualifying event is the day your employment terminated or another qualifying event occurred. Under the law, you must elect continuation coverage within 60 days from the date you lost coverage as a result of one of the events described above, or, if later, 60 days after Western Governors University provides notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

If you elect continuation coverage, Western Governors University is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. If the coverage for similarly situated employees or family members is modified, your coverage will be modified, too. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

To inquire about COBRA coverage, contact your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu).

## **Duration of COBRA**

The law requires that you be provided the opportunity to maintain continuation coverage for up to 18 months if you lose group health coverage because of a termination of employment or a reduction in work hours.

COBRA continuation coverage is available for your spouse/partner and eligible dependents for up to 36 months when the qualifying event is the death of the covered employee, divorce or legal separation, the covered employee becoming entitled to Medicare, or a dependent child's loss of eligibility as a dependent child.

Additional qualifying events may occur while the continuation coverage is in effect after an initial qualifying event, such as loss of employment. Examples of such events are the death of the covered employee, divorce, legal separation, the covered employee becoming entitled to Medicare, or a dependent child's loss of dependent status.

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse/partner and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu) if a second qualifying event occurs during your continuation coverage period.

When COBRA medical coverage ends, generally you cannot convert your coverage to an individual medical policy.

## **Special Rules for Disability**

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination of employment or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu) within 60 days of the SSA determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that the qualified beneficiary is no longer disabled, the individual must inform your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu) of this redetermination within 30 days of the date it is made, at which time the 11-month extension will end.

If you or a covered family member is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period for your qualified beneficiaries is 36 months after your termination of employment or reduction in hours.

## **Medicare**

If, within 18 months after becoming entitled to Medicare, you subsequently lose Plan coverage due to your termination of employment or reduction in hours, your eligible dependents' COBRA coverage will not end before 36 months from the date you became entitled to Medicare. However, your eligible dependents' COBRA coverage will not extend beyond 36 months.

The law provides that continuation coverage may be cut short prior to the expiration of the 18-, 29- or 36-month period for any person who elected COBRA for any of the following five reasons:

- Western Governors University no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the covered individual;
- The person who elected COBRA becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and SSA makes a final determination that the individual is no longer disabled.

## **COBRA and FMLA**

A leave that qualifies under the FMLA does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of non-payment of premiums during an FMLA leave or you decide not to return to active employment, you are still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

- When you definitively inform Western Governors University that you are not returning to work at the end of the leave; or
- The end of the leave, and you do not return to work.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your spouse and/or dependent child is covered by the Plan on the day before the leave begins; and
- You do not return to work at the end of the FMLA leave.

## **Your Duties**

Under the law, the employee or a family member is responsible for notifying Western Governors University of:

- A divorce or legal separation;
- The loss of a child's dependent status under the Plan;

- An additional qualifying event (such as a death, divorce or legal separation) that occurs during the employee's or family member's initial continuation coverage period of 18 (or 29) months;
- A determination by the SSA that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage period of 18 months; or
- A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice must be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status or an additional qualifying event. In the case of a disability determination, the notice must be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage.

If the employee or a family member fails to provide this notice to Western Governors University during this notice period, any individual(s) who loses coverage will not be offered the option to elect continuation coverage.

The notice may be in writing and must include the following information:

- The applicable plan name;
- The identity of the covered employee and any qualified beneficiaries;
- A description of the qualifying event or disability determination;
- The date on which it occurred; and
- Any related information customarily and consistently requested by the Plan's COBRA Administrator.

Mail this information to the address below if the covered person is an active employee of Western Governors University

Western Governors University:

4001 S 700 E STE 700  
Salt Lake City, UT 84107  
benefits@wgu.edu

When Western Governors University is notified that one of these events has occurred, Western Governors University in turn, will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify Western Governors University and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child's loss of dependent status, you and your family members may be required to reimburse the Plan for any claims mistakenly paid.

## **Western Governors University's Duties**

If any of the following events results in a loss of coverage, qualified beneficiaries will be notified of the right to elect continuation coverage automatically without any action required by the employee or a family member:

- The employee's death or termination of employment (for reasons other than gross misconduct); or
- A reduction in the employee's hours of employment.

## **Cost of COBRA Coverage**

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you will be required to pay 150% of the premium beginning with the 19th month of continuation coverage.

The cost of group health coverage periodically changes. If you elect continuation coverage, Western Governors University will notify you of any changes in the cost. If coverage under the Plan is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way. You and your family members will be subject to these changes in the cost of coverage.

The initial payment for continuation coverage is due 60 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 60 days.

If you have any questions about COBRA coverage or the application of the law, contact the COBRA Administrator at the address below. If the covered person has terminated employment with Western Governors University and your marital status has changed, or you or a qualified beneficiary has changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you may notify the COBRA Administrator in writing immediately to:

Western Governors University:

4001 S 700 E STE 700  
Salt Lake City, UT 84107  
benefits@wgu.edu

## **Plan Documents**

Every effort has been made to ensure that the information included is a summary of your benefits. If there is an inconsistency between any of the terms of the official Plan documents or SPD with regard to Plan benefits, the terms of the official Plan document will govern.

All benefits are authorized and subject to federal tax laws, such as the Internal Revenue code and other federal and state laws, which may affect your rights. The provisions of the Plan are subject to revision due to a change in laws or pronouncements by the Internal Revenue Services or other federal agencies.

Copies of all Plan documents are available for review upon written request to the plan administrator. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized

representative) upon request. A reasonable fee may be charged for the copies as permitted under the Employee Retirement Income Security Act of 1974 (ERISA).

## **Your HIPAA Privacy Rights**

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. The notice will describe how the Plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment or healthcare operations). In addition, the notice will describe your rights with respect to your health information.

As required by law, every three years Western Governors University distributes a HIPAA Privacy Notice to you via mail. You should retain this notice with your personal records.

Refer to the Plan's privacy notice for more information. You can obtain a copy of the HIPAA Privacy Notice by contacting your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu)

## **Non-Assignment of Benefits**

Generally, benefits under the Prescription Drug Plan may not be sold, transferred, pledged or assigned except as permitted by law. In certain situations, however, court orders (including qualified medical child support orders and qualified domestic relations orders) may require benefits to be provided for a certain individual or individuals, typically an employee's family member.

## **Qualified Medical Child Support Order (QMCSO)**

A qualified medical child support order, also known as a QMCSO, is any judgment, decree or order, including a court-approved settlement agreement, that is issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which you or your beneficiary is eligible. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. The Plan reviews the medical child support order to determine whether or not it meets the criteria for a QMCSO. Keep in mind that a medical child support order cannot require the plan to provide coverage it doesn't otherwise offer—for example, children who are no longer eligible due to their age can't be added under a QMCSO.

If a QMCSO affects you, you should notify your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu) so that the order can be handled properly. You and your dependents may obtain a copy of the procedures governing the QMCSO without charge by calling your Plan Sponsor at [benefits@wgu.edu](mailto:benefits@wgu.edu). If Western Governors University receives a QMCSO affecting you, you'll be notified. The Plan will comply with all valid QMCSOs.

## **Change or Termination of the Plan**

Western Governors University reserves the right to amend, modify, suspend or terminate the Prescription Drug Plan in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason, regardless of your status at the time of the change.

A decision to terminate, amend or replace the Plan may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service (IRS) or ERISA or for any other reason. This may include elimination of or decreases in benefits, changes in Plan networks and/or increases in your required contributions for coverage. If the Plan is terminated or changed, you'll still be paid any benefits you were entitled to receive under the terms of Plan, up to the cancellation date or date of the change.

## **Employment Rights Not Implied**

This summary plan description is for your information only; it is not a binding contract, nor does it impose any legal obligation upon Western Governors University. The Plan and the benefits described in this summary plan description do not imply or create a contract or guarantee of continued employment between Western Governors University and any individual. Employment with Western Governors University is "at will" and may be terminated by either party at any time, with or without cause or notice, except as provided by the terms of any applicable collective bargaining agreement. This provision applies to all employees regardless of their hire date.

Participation in Western Governors University benefits doesn't give you a right to any benefit to which you're not entitled under the terms of the Plan.

## **Your Rights under ERISA**

As a participant in the Prescription Drug Plan, you're entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to each of the rights described here.

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

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, upon request, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the Plan's annual financial report, if any is required to be prepared under ERISA.

## **Continue Group Prescription Drug Plan Coverage**

You may continue healthcare coverage for yourself, your spouse/domestic partner or your 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 the summary plan description for the Plan in which you are enrolled and the documents governing the Plan on the rules governing your COBRA coverage rights.

## **Prudent Actions by Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a 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 the Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials weren't sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part and you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court, after exhausting the Plan's claim and appeals procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you're 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, after exhausting the Plan's claims and appeals procedures. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

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

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.