

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.

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How the Prescription Drug Program Works

Eligibility

You are eligible to enroll for the Surest Plan for coverage if you are:

- An eligible employee who is scheduled to work at least 30 hours per week.
- An eligible dependent of the employee such as:
 - A legal spouse or domestic partner.
 - A domestic partner means an unrelated individual of the same or opposite sex for which the employee and domestic partner complete and sign the Plan Sponsors Affidavit of Domestic Partnership and Dependency or Non-dependency of Domestic Partner and Children.
 - You or your spouse's / domestic partner's child who is under the age of 26, including:
 - a natural child.
 - a stepchild.
 - a legally adopted child.
 - a child placed in foster care.
 - a child placed for adoption.
 - a child for whom you or your spouse are the legal guardian.
 - Your child age 26 or over who is disabled and dependent upon you (see additional information below).
 - A dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

An employee must enroll in the Surest Plan coverage in order to enroll his/her dependents. If both parents are covered as employees, a child may be covered as a dependent of either parent, but not both. Employees and eligible dependents enrolled in the Surest Plan for coverage are referred to as 'Participants' in this SPD.

Coverage for any child who is mentally or physically handicapped, mentally ill, or developmentally disabled, as determined by the Social Security Administration, and incapable of self-sustaining employment may continue to be enrolled in the Plan after they reach the limiting age of 26 if their disability began prior to such age. An illness that does not cause a child to be incapable of self-sustaining employment will not be considered a physical disability. The disabled child must be dependent on you for financial support, as defined by the Internal Revenue Code, and the covered employee must claim the disabled child as a dependent for IRS income tax purposes. The employee must provide proof that the child is incapable of self-sustaining employment within 31 days of the date the child reaches the limiting age of 26. The

disabled child must meet the above support requirements and submit proof of disability to the Plan Administrator upon request.

A newly hired employee may also add a disabled child as a dependent under the Surest Plan provided the child is incapable of earning his own living and the disability began prior to reaching the limiting age of 26. The disabled child must be dependent upon you for financial support, as defined by the Internal Revenue Code, and the covered employee must declare the child as an income tax deduction.

The Plan Administrator may require documentation proving financial dependency, including tax records and proof of continuous coverage under any previous plan(s). At the Plan Administrator's discretion, subsequent proof of medical disability and financial dependency may be requested from the employee. The Plan Administrator reserves the right to have such child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine such incapacity.

Enrolling for Coverage

How Do You Enroll?

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

To enroll in the Surest Plan for coverage, contact the Plan Administrator within 31 days of the date you first become eligible for the Surest Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Open Enrollment to make your benefit elections.

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child, placement for foster care of a child, or other family status change, you must contact the Plan Administrator within 31 days of the event. Otherwise, you will need to wait until the next Open Enrollment to change your election.

Each year during Open Enrollment, you have the opportunity to review and change your election. Any changes you make during Open Enrollment will become effective the following Plan Year Effective Date.

When Do You Enroll and When Does Coverage Begin?

If you enroll yourself in the Surest Plan during Open Enrollment, your coverage is effective on the first day of the Plan Year. For employees who are hired mid-year, coverage will begin on the employee's date of hire and once the Plan Administrator receives your properly completed enrollment information.

Coverage for eligible dependents that you properly enroll during Open Enrollment is effective on the same day your coverage begins.

Coverage for a dependent spouse or stepchild added through marriage is effective on the date of your marriage, provided you notify the Plan Administrator within 31 days of your marriage.

Coverage for dependent children added through birth, adoption, placement for adoption, or placement for foster care is effective on the date of the family status change, provided you notify the Plan Administrator within 31 days of the birth, adoption, or placement.

Coverage for eligible domestic partners and their children become effective the date of your partnership provided you notify Human Resources within 31 days and sign the Plan Sponsor's Affidavit of Domestic Partnership and Dependency or Non-dependency of Domestic Partner and Children.

Initial Enrollment Period

To enroll in the Surest Plan for coverage, contact the Plan Administrator within 31 days of the date you first become eligible for the Surest Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Open Enrollment to make your benefit elections.

Open Enrollment Period

Open Enrollment is held before the start of the Plan Year. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following Open Enrollment. You will receive information, including instructions on how to enroll, before Open Enrollment each year.

Special Enrollment Period: Due to Status Change

You may make Surest Plan coverage changes during the Plan Year if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your new spouse following your marriage, your new child following an adoption, etc.). The following are considered family status changes for purposes of the Surest Plan:

- Your marriage, divorce, legal separation, or annulment.
- The birth, legal adoption, placement for adoption, placement for foster care, or legal guardianship of a child.
- A change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a dependent.
- Your dependent child no longer qualifying as an eligible dependent.
- A change in your or your spouse's position or work schedule that impacts eligibility for health coverage.
- The company or other employer ceased its contribution toward the premium for the other plan or contract.
- A change in residence.
- You or your eligible dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible dependent.

- Benefits are no longer offered by the plan to a class of individuals that include you or your eligible dependent.
- Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Plan Administrator within 60 days of termination).
- You or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Plan Administrator within 60 days of the date of determination of subsidy eligibility).
- You or your dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your dependent may enroll in other individual market coverage, through or outside of a Marketplace.
- A strike or lockout involving you or your spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you or your eligible dependent do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Note: Any child under the age of 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Surest Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Eligibility for Children's Health Insurance Program (CHIP) or Medicaid Coverage

If an eligible employee and/or his/her eligible dependents are covered under a state Medicaid Plan or a state CHIP (if applicable) and that coverage is terminated as a result of loss of eligibility, then such employee may request enrollment in the Plan on behalf of him/herself and/or eligible dependents. Such request shall be submitted to the Plan Administrator no later than 60 calendar days after the eligible employee's and/or his/her dependent's coverage ends under such state plans.

If an eligible employee and/or his/her eligible dependents become eligible for coverage under a state Medicaid Plan or a state CHIP (if applicable), and the employer has not opted out of the premium assistance subsidy offered by the state, then such employee may request enrollment

in the Plan on behalf of him/herself and/or such eligible dependents. The eligible employee shall request such enrollment in the Plan no later than 60 calendar days after the date the employee and/or his/her eligible dependents are determined to be eligible for coverage under such state plans.

Coverage will be effective on the first day of the first calendar month beginning after the date the Plan Administrator receives the request for special enrollment due to eligibility for Medicaid or CHIP payment assistance, provided the Plan Administrator receives the application for coverage as required.

Unless otherwise noted above, if you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next Open Enrollment.

Making Changes During the Year

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child, placement for foster care of a child, or other family status change, you must contact the Plan Administrator within 31 days of the event. Otherwise, you will need to wait until the next Open Enrollment to change your election.

Coverage While on a Leave of Absence

Family and Medical Leave Act (FMLA) Leave

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.

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. You are responsible for all required premium contributions for the Surest Plan while on leave of absence. Such coverage will continue until the earlier of the expiration of such leave or the date you notify your employer that you do not intend to return to work.

If you do not return after an approved leave of absence, you may be eligible to continue coverage, provided that you elect to continue coverage according to page 24 (Continuation of Coverage) of this SPD. If the covered employee returns to work immediately following his/her approved FMLA leave, no new waiting periods will apply.

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

Although USERRA protections look similar to COBRA protections, USERRA rights are separate and independent from COBRA rights.

In addition to COBRA rights, a Participant may be entitled to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). USERRA requires your employer to offer employees and their spouse and/or dependent children the opportunity to pay for a temporary extension of health coverage (called "USERRA continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services (e.g., for service in the military).

This section is intended to inform Participants, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your USERRA continuation coverage rights. For additional information about your rights and obligations under the Surest Plan and under federal law, you should contact the Plan Administrator.

Service Leave Event. If covered under the Surest Plan, the employee has the right to elect USERRA continuation coverage for him/herself, his/her spouse, and his/her dependents if they lose coverage under the Surest Plan due to an absence from employment for service in the uniformed services (a "service leave").

Service in the Uniformed Services. Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have 60 days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered made on the postmark date. If USERRA continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If USERRA continuation coverage is not elected within this period, coverage under the Surest Plan ends. However, if no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Unlike COBRA, USERRA does not give your spouse or dependent child(ren) an independent right to elect USERRA continuation coverage. Their coverage may be continued only if you elect USERRA continuation coverage.

Maximum Continuation Period. The law requires that you generally be allowed to maintain USERRA continuation coverage for a 24-month period beginning on the date of your absence from employment for the purpose of performing service begins.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or dependents that are not on service leave.

Cost. A Participant electing USERRA continuation coverage may be required to pay all or part of the cost of USERRA continuation coverage. If you perform service in the uniformed services for fewer than 31 days, you will pay the same amount for the coverage that you normally pay. If your service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan providing the coverage. Payment is generally due monthly on the first day of the month. Payment is considered made on the postmarked date. You will be given a grace period of 30 days within which to make the payment.

Termination of the Continuation of Coverage. The USERRA continuation coverage may be terminated before the end of the maximum continuation period for any of the following reasons:

- The employers no longer provides group health coverage to any of its employees.
- The premium for USERRA continuation coverage is not paid on time (including the grace period).
- Termination for cause under the generally applicable terms of the Surest Plan (e.g., submission of fraudulent benefit claims).

General Information about When Coverage Ends

Your coverage will terminate on the earliest of the following dates:

- The date the Plan is terminated.
- The end of the month which employee terminates.
- The date your eligibility under the Plan ends.
- When you do not make your required premium contribution for coverage under the Surest Plan. Termination will be retroactive to the last day for which your required premium contribution was timely received.
- The date you, or someone acting on your behalf, performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the Plan.
- The last day of the month in which the status as domestic partner or dependent children of the domestic partner as attested in the Affidavit of Domestic Partnership and Dependency or Non-dependency of Domestic Partner and Children change results in the domestic partner and/or the dependent children of the domestic partner no longer qualifies for coverage under the Plan.
- The last day of the month in which a covered dependent child turns 26.
- The last day of the month in which a covered disabled dependent child age 26 or over ceases to be disabled.

Participant's Responsibility to Notify

In certain circumstances, you are required to provide notification to the Plan Administrator to protect your rights under COBRA. These circumstances are:

- **Notice of Qualifying Event.** Under the law, the Participant (or a representative acting on behalf of the Participant) has the responsibility to inform the Plan Administrator of a spouse or child losing dependent status under the Surest Plan within 60 days of the latest of:
 - The date of the qualifying event.
 - The date coverage would be lost because of the qualifying event.
 - The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

The notice must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the 60-day notice period described above. The notice must:

- State the name of the Surest Plan.
- State the name and address for the employee or former employee who is or was covered under the Surest Plan.
- State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event.
- Include a detailed description of the event.
- Identify the Effective Date of the event.
- Be accompanied by any documentation providing proof of the event (e.g., a death certificate).

If the required notification is not received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within 30 days. If the missing information is not provided within that time, the notification will be ineffective, and no continuation coverage will be provided.

- **Notice of the Second Qualifying Event.** In addition, the Participant (or a representative acting on behalf of the Participant) must notify the Plan of the death of the employee or a spouse or dependent child ceasing to be eligible for coverage as a dependent under the Surest Plan, if that event occurs within the 18-month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within 60 days after such a second qualifying event occurs for the qualified beneficiary to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan at the address identified below. Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable.

Your notice must be postmarked no later than the last day of the 60-day notice period described above. The notification must:

- State the name of the Surest Plan.
- State the name and address for the employee or former employee who is or was covered under the Surest Plan.
- State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event and who are receiving COBRA coverage at the time of the notice.
- Identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage.
- Include a detailed description of the event.
- Identify the Effective Date of the event.
- Be accompanied by any documentation providing proof of the event (e.g., divorce decree).

If the required notification is not received within the required time period, no extension of the continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within 30 days. If the missing information is not provided within that time, the notification will be ineffective, and no extension of the continuation period will be provided.

- **Notice of Disability.** The Participant (or a representative acting on behalf of the Participant) must notify the Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within 60 days of the latest of:
 - The date of the disability determination.
 - The date of the qualifying event.
 - The date coverage would be lost because of the qualifying event.
 - The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

In addition, the notice must be provided before the end of the first 18 months of continuation coverage.

The notice must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone, is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notice must be postmarked no later than the last day of the 60-day notice period described above. The notification must:

- State the name of the Surest Plan.
- State the name and address of the Employee or former employee who is or was covered under the Surest Plan.

- State the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice.
- Identify the nature and date of the initial qualifying event that entitled the qualified beneficiaries to COBRA coverage.
- State the name of the disabled qualified beneficiary.
- Identify the date upon which the Social Security Administration made its determination of disability.
- Include a copy of the determination of the Social Security Administration.

If the required notification is not received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the Plan to which it applies, the identity of the Employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within 30 days. If the missing information is not provided within that time, the notification will be ineffective, and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the Plan Administrator of that determination with 30 days or the later of:

- The date of the termination.
- The date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so.

The notice must be in writing and be mailed to the Plan Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins 30 days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Surest Plan reserves the right to seek reimbursement of any Benefits provided by the Surest Plan between the date coverage terminates and the date the notification is provided.

Failure to provide timely and complete notice ends the right to COBRA continuation coverage.

Fraud or Intentional Misrepresentation of a Material Fact

Coverage will end the date you, or someone acting on your behalf, performed an act or practice that constitutes fraud or made an intentional misrepresentation (including and omission) of material fact under the terms of the Plan.

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.

| Prescription Drug Plan | Informed Choice |
|--|--|
| Annual Plan Deductible (Integrated with medical) | |
| Network Pharmacy: | Individual – Does not apply Family – Does not apply |
| Out-of-Network Pharmacy: | Individual – Does not apply Family – Does not apply |
| Annual Out-of-Pocket Maximum (Integrated with medical) | |
| Network Pharmacy: | \$3,000 Individual \$6,000 Family |
| Out-of-Network Pharmacy: | \$8,000 Individual \$16,000 Family |

| Prescription Drug Plan | Informed Choice |
|---|---|
| Retail from a Network Pharmacy (up to 30 day supply) | Tier 1: \$10.00 Tier 2: \$40.00 Tier 3: \$80.00 |
| Retail 90 from a Network Pharmacy (up to 90 day supply) | Tier 1: \$20.00 Tier 2: \$80.00 Tier 3: \$160.00 |
| Mail Order Pharmacy (up to a 90-day supply) | Tier 1: \$20.00 Tier 2: \$80.00 Tier 3: \$160.00 |
| Specialty Medications (up to 30 day supply) | Tier 1: \$20.00 Tier 2: \$80.00 Tier 3: \$160.00 |
| Out-of-Network Pharmacy (up to 30 day supply) | Tier 1: 60% coinsurance Tier 2: 60% coinsurance Tier 3: 60% coinsurance Specialty: Not Covered |

The Informed Choice 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 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 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 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. 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 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. 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.

- 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 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).

PrudentRx Program

The PrudentRx Copay Program assists you by helping you enroll in manufacturer copay assistance programs. Medications on the PrudentRx specialty drug list and exclusively dispensed by CVS' specialty network are included in the program and will be subject to a 30% coinsurance. However, if you enroll in the PrudentRx Copay Program, you will receive a copay card for your specialty medication (if applicable), and you will have a zero dollar (\$0) cost share for your prescriptions covered under the Program.

PrudentRx will assist you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible medications thereby reducing your out-of-pocket expenses.

If you currently take one or more specialty medications included on the PrudentRx Program Drug List, or are prescribed one in the future, you will be contacted by PrudentRx, and they will assist you in enrolling in manufacturer copay assistance for your medication. All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt out.

If you opt out of the PrudentRx Copay Program, or do not affirmatively enroll in any copay assistance, you will be responsible for 30% coinsurance on specialty medications that are eligible for the PrudentRx program. Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible (if applicable). Also, because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by your or a manufacturer copayment assistance program, do not count towards the Plan's out of pocket maximum.

The PrudentRx Program Drug List may be updated periodically and may be found online at www.caremark.com.

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 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.

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 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 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 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

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 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. 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.