THE GEORGE WASHINGTON UNIVERSITY

FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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INTRODUCTION

The George Washington University (the "university") sponsors The George Washington University Flexible Benefits Plan (the "Plan"). The Plan allows eligible employees to (i) contribute toward health, vision and dental premiums using before-tax money, and (ii) to set aside money on a before-tax basis in order to reimburse themselves for qualified health expenses and qualified dependent care expenses.

The Plan includes three vehicles for paying for benefits on a pre-tax basis, each of which is described in more detail in this Summary Plan Description ("SPD") booklet.

- Premium payments under the university's Health and Welfare Benefit Plan for the medical, dental, and vision benefit options ("Before-Tax Premium Payments");
- The Health Care Flexible Spending Account ("Health Care FSA"); and
- The Dependent Care Flexible Spending Account ("Dependent Care FSA").

Keep in mind, you cannot transfer contributions made to the Plan between these three vehicles, as each vehicle is treated separately from the others.

This booklet is the summary plan description ("SPD") of the Plan, and is intended to provide you with a general understanding of the Plan. This SPD does not state all of the terms and conditions of the Plan. Detailed provisions of the Plan are contained in the official Plan document. **If there is any conflict between this SPD and the Plan document, the Plan document will control.**

This booklet also includes a description of the Heath Savings Account ("HSA") program. A Health Savings Account is an account established by you in your name for payment of certain medical expenses on a tax free basis. Unlike the benefits listed above, the Health Savings Account program is not covered by the federal law governing employee benefits, the Employee Retirement Income Security Act of 1974 ("ERISA"). Therefore, the portions of this booklet that relate only to ERISA-covered benefits (such as the benefit claims and appeals provisions, and the election change rules) do not apply to the Health Savings Account.

You can review the Plan document and other documents concerning the Plan, and you may obtain copies of the documents constituting the Plan, by contacting GW Benefits at (571) 553-8382 (a reasonable charge may be imposed for copies, as permitted by federal regulations).

The Plan Administrator has the discretionary authority to interpret Plan provisions and apply them to specific situations, and benefits are paid from the Plan only if the Plan Administrator determines that a participant is entitled to those benefits under the Plan terms. Please contact the Plan Administrator at (571) 553-8324 if you have questions about this SPD, the Plan or any other Plan materials.

ELIGIBILITY TO PARTICIPATE

Employees Eligible for Participation

Only a Benefits-Eligible Employee is eligible to participate in the Plan. However, a Benefits-Eligible Employee enrolled in the GW Health Savings Plan ("HSP") with optional Health Savings Account medical coverage under the university's Health and Welfare Benefit Plan may not enroll in the Health Care FSA. Only a Benefits Eligible Employee enrolled in the HSP who is not eligible for an optional Health Savings Account may enroll in the Health Care FSA. If you disagree with the Plan Administrator's determination as to eligibility, you may appeal in accordance with the procedures described under *"Plan Eligibility Determinations"* on page 21.

Benefits-Eligible Employee – Any individual on the payroll of the university, and not paid by accounts payable, whose wages from the university are subject to withholding for the purposes of federal income taxes and the Federal Insurance Contributions Act. The term Benefits-Eligible Employee will not include:

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

Effective on and after June 1, 2017, a Benefits-Eligible Employee shall include a Tenured Faculty Member who is enrolled in the Plan, approved for long-term disability benefits under the university's Health and Welfare Benefit Plan and remains on a leave of absence (whether paid or unpaid) from the university.

Faculty Member –

- **Full-Time Faculty Member –** A Benefits-Eligible Employee who is appointed for at least one academic year in one of the regular, specialized (e.g. research and special service faculty), or visiting ranks listed in the Faculty Code and who devotes 100% effort to the duties of the position, and who receives a salary through the university. Faculty appointed on a temporary basis (one semester or less) are not included. Full-Time Faculty Member also includes a partial retiree as provided in the Faculty Code, which is a Benefits-Eligible

Employee who is a Full-Time Faculty Member who reduces their workload to either a two-thirds or a half-time basis. Such partial retiree will continue to be eligible for benefits as a Full-Time Faculty Member during the partial retirement period.

- **Part-Time Faculty Member** – A Benefits-Eligible Employee who is generally appointed for one academic year and who devotes less than 100% effort to university duties (with the exception of a partial retiree, described above under "Full-Time Faculty Member."). Part-time faculty who are on one-semester appointments or who are compensated on a per-course basis are not included.

- **Tenured Faculty Member** – A Faculty Member who has been appointed and approved for tenure as provided in the university's Faculty Code.

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

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

- **Full-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 40 hours per week.[1]

- **Part-Time Staff Member** – A Benefits-Eligible Employee who is regularly scheduled to work at least 14 hours a week but less than 40 hours per week.[1]

Participation During a Leave of Absence

The university permits employees to take leave for a variety of reasons. Categories of leave include vacation, sick, personal, administrative, qualified military, Family and Medical Leave Act, leave as an accommodation under the Americans with Disabilities Act, leave for educational purposes, and leave for disciplinary reasons. The following paragraphs address how benefits under the Plan are affected when you take a leave of absence.

Dependent Care FSA

The following paragraphs set forth the rules for participation in the Dependent Care FSA during leaves of absence. In the Dependent Care FSA, the rules are the same for paid and unpaid leaves.

Under the Dependent Care FSA, benefits will continue during an approved leave of absence lasting 30 calendar days or less unless you terminate your participation.

If your leave of absence exceeds 30 calendar days, your participation in the Dependent Care FSA will cease on the last day of the month in which your leave of absence began. You may continue to submit dependent care expenses incurred through the last day of the month in which the leave of absence began.

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

Before-Tax Premium Payments and Health Care FSA

The following paragraphs set forth the rules for participation in the Before-Tax Premium Payments and Health Care FSA during paid and unpaid leaves of absence.

Paid Leaves of Absence

If you are on a paid approved leave of absence, including paid suspension or administrative leave, your participation in the Before-Tax Premium Payments and Health Care FSA will continue and your regular payroll deductions will continue.

Unpaid Leaves of Absence

If your unpaid leave is 30 calendar days or less, your Before-Tax Premium Payments will accrue in arrears and be deducted from your pay upon your return to work. If your unpaid leave of absence exceeds 30 calendar days, your Before-Tax Premium deduction will cease. Health Care FSA deductions will cease as soon as you begin an unpaid leave, and you must decide whether to cease participation in the Health Care FSA. If you elect to continue your participation in the medical, dental, vision or Health Care FSA plans, you will be responsible for remitting your contributions directly to the university in a timely fashion on an after-tax basis. If you fail to make contributions or decide not to continue participation, then any eligible Health Care FSA expenses incurred during your period of non-participation will not be reimbursable. If you elect to cease, you will be permitted to reinstate your coverage when you return from leave. See Return from a Leave of Absence, below.

You may cancel your participation within 30 calendar days of the start of your unpaid leave of absence through EasyEnroll at *go.gwu.edu/easyenroll*.

Exceptions to the policies regarding unpaid leaves of absence are described below.

Unpaid FMLA, ADA and Qualified Military Leaves

If you are on approved, unpaid Family Medical and Leave Act ("FMLA") Leave, leave as an accommodation under the Americans with Disabilities Act ("ADA"), or Qualified Military Leave, then you may continue to participate in the medical, dental, and vision plans, and Health Care FSA, through the duration of your leave of absence as described below. (A Qualified Military Leave is an authorized leave of absence that is taken pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as amended.)

If your unpaid FMLA Leave, leave under the ADA or Qualified Military Leave is 30 calendar days or less, your Before-Tax Premium Payments will accrue in arrears and be deducted from your pay upon your return to work. If your unpaid leave of absence exceeds 30 calendar days, your Before-Tax Premiums will cease. Health Care FSA deductions will cease as soon as you begin an unpaid leave, and you must decide whether to cease participation in the Health Care FSA. If you elect to continue your participation in the medical, dental, vision or Health Care FSA plans, you will be responsible for remitting your contributions directly to the university on an after-tax basis. If you elect to cease, you will be permitted to reinstate your coverage when

you return from leave. For FMLA, ADA, and Qualified Military leaves, your coverage will be reinstated effective on your return date provided you timely re-enroll.

Note: If you are on FMLA Leave, leave under the ADA or Qualified Military Leave, your leave of absence may be paid, unpaid, or a combination of paid and unpaid depending on your accumulated paid time off balances. (Refer to the university's Family and Medical Leave and Military Leave Policies.) If you remain in paid status during these types of leave of absence, your contributions will be deducted from your pay as normal. If the cost of your contributions exceeds your pay during your leave, the remaining unpaid Before-Tax Premium Payments will accrue in arrears and be deducted from your next paycheck.

You may cancel your participation within 30 calendar days of the start of your unpaid leave of absence through EasyEnroll at *go.gwu.edu/easyenroll*.

During Short-Term Disability

If you are approved for GW paid short-term disability benefits, your Before-Tax Premium Payments and Health Care FSA will continue through the duration of your leave of absence. Deductions from your pay for your contributions will continue as normal. If you are approved for voluntary short-term disability benefits, your Before-Tax Premium Payments and Health Care FSA will continue through the duration of your leave of absence for as long as you have annual time or sick time that provides a stream of payments from the university. Once payments from the university cease, your benefits may continue as described above under the heading, "Unpaid Leaves of Absence."

During Long-Term Disability

- Tenured Faculty Members

  If you are a Tenured Faculty Member approved for long-term disability benefits, you may continue your Pre-Tax Premium Payments and Health Care FSA under the Plan until the end of your approved long-term disability benefit, if you continue to receive pay from the university.

- Non-Tenured Faculty Members and all Staff Members

  If you are a non-Tenured Faculty Member or Staff Member approved for long-term disability benefits on or after June 1, 2017, your employment with the university is terminated and your participation in the Plan will end at the end of the month in which you are terminated, unless you elect continuation coverage for your Health Care FSA as described under "*Continuation of Health Care FSA Coverage – COBRA*" on page 24.

If you are considering a settlement with the long-term disability insurance carrier, your eligibility for some benefits may be impacted. Contact GW Benefits for further information on the impact of a settlement on your benefits.

Return from a Leave of Absence

If your participation continued during your leave of absence and you return to active employment, you do not need to take any action.

If your participation in a benefit plan ends during a leave of absence of 30 days or more, you must take action promptly when you return from leave if you wish to re-enroll. You will not be automatically re-enrolled. If you choose to re-enroll, your medical, dental and vision coverage must be the same coverage you elected prior to your leave of absence. Your FSA elections must be the same or less than the election you made prior to your leave. You may modify your elections if you experienced a qualifying life event during your leave of absence, or if a new Plan Year has begun. Qualifying life events are explained in the Enrollment and Election Changes section of this SPD. You must re-enroll in benefits within 30 calendar days of your return to work through EasyEnroll, or wait for next open enrollment to re-enroll.

If your participation in a benefit plan ends during a leave of absence of less than 30 days, you must re-enroll in the same benefits you elected before your leave of absence unless you had a documented qualifying life event. If you fail to re-enroll within 30 days of your return, GW Benefits will take action on your behalf.

If your benefits continued during your unpaid leave of absence is less than 30 days in duration, you premiums will accrue in arrears and be deducted from your pay upon your return to work.

For most types of leave, your coverage will begin on the first of the month coincident or next following your return from leave, depending on how quickly you re-enroll. For FMLA, ADA, and Qualified Military leaves, your coverage will be reinstated as of your return date, provided you timely re-enroll.

Questions

Please contact GW Benefits at (571) 553-8382 for information regarding your participation or payment of contributions while on approved leave of absence.

ENROLLMENT AND ELECTION CHANGES

Initial Enrollment

You are eligible for the Plan as of the first day of the month coincident with or following the date you are eligible for participation, as shown on page 2. If you wish to participate in the Plan, you must use the university's online enrollment tool called EasyEnroll, which can be accessed at *go.gwu.edu/easyenroll,* or such other process the Plan Administrator requires. You can't participate in the Plan until you enroll in accordance with procedures set forth by the Plan Administrator. Required supporting documents must be submitted to GW Benefits no later than 30 calendar days from your first day of eligibility. If you fail to use the online enrollment tool and provide the required documentation, you will not be enrolled.

If you elect health, vision and/or dental coverage under the university's Health and Welfare Benefit Plan, then you are automatically enrolled for Before-Tax Premium Payments. Enrollment in the Health Care FSA and Dependent Care FSA must be completed as described above no later than 30 calendar days from your first day of eligibility.

If you do not complete the online enrollment and provide supporting documentation within 30 calendar days of your eligibility date, you will not be able to enroll in the Plan until the next open enrollment period, unless you experience a qualifying life event as described below.

Re-Enrollment

Re-Employment

Within 30 Calendar Days - If your employment terminates and you are rehired within 30 calendar days, then you must re-enroll with the same elections that were in effect on your date of termination. Your coverage will be effective on the first of the month coincident with or next following your re-employment, depending on how quickly you re-enroll, and will be prospective only. However, you may modify your elections if you experienced a qualifying life event or if a new Plan Year has begun. If you fail to take action within 30 days of your rehire, GW Benefits will take action on your behalf.

More than 30 Calendar Days - If your employment terminates and you are rehired later than 30 calendar days after your termination date, then you are treated as a newly eligible participant and are subject to the initial enrollment provisions described above. You must take action to re-enroll within 30 calendar days of your return to work, or wait for the next open enrollment to re-enroll. You will not be automatically re-enrolled.

Return from Leave of Absence

See *"Return from a Leave of Absence"* on page 6.

Open Enrollment

During each annual open enrollment period, you have the opportunity to make new benefit choices for the upcoming Plan Year (January 1 through December 31). **If you wish to continue**

your participation in the Health Care FSA or the Dependent Care FSA, you must re-enroll and make new elections each year. If you do not re-enroll during open enrollment, the Plan Administrator assumes that you do not want to continue your participation in the Health Care FSA or the Dependent Care FSA for the upcoming Plan Year, you will not be enrolled in either, and you will not be eligible to re-enroll until the next open enrollment period, unless there is a qualifying life event as described below.

Changes to Enrollment Election

Generally, you may not make changes to your before-tax health, vision and dental deductions, Health Care FSA and Dependent Care FSA elections during the Plan Year, but you may change your elections during the Plan Year if you experience a "a qualifying life event." Your election change must be consistent with the qualifying life event, and you must go online to *go.gwu.edu/easyenroll* within 30 calendar days of the qualifying life event to make changes. The chart below lists events considered to be a qualifying life event.

Qualifying Life Event Examples	
Before-Tax Health, Vision and Dental Premiums and Health Care FSA • Marriage, death of spouse, divorce, legal separation, annulment. • Birth, adoption or death of dependent ("dependent" is defined under the "*Covering Eligible Health Care Expenses Using Your Health Care FSA*" section on page 12). • Change in your or your spouse's employment status (that causes a loss or gain of benefits). • Changes as may be required pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires you to provide health coverage for a child. • Entitlement to Medicare or Medicaid. • Changes in coverage of your spouse, former spouse or dependent under another employer's plan.* • Revocation of your medical benefit election due to enrollment in a qualified health plan through a health insurance marketplace.* • Revocation of your medical benefit election due to a reduction in hours of service.*	Dependent Care FSA • Marriage, death of spouse, divorce, legal separation, annulment. • Birth, adoption or death of dependent (who is a "qualifying individual" as defined under the "*Covering Eligible Dependent Care Expenses Using Your Dependent Care FSA*" section on page 17). • Change in your or your spouse's employment status (that causes a loss or gain of benefits). • Changes as may be required pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires you to provide health coverage for a child. • Significant cost change (increase or decrease) imposed by a dependent care provider who is not your relative.

* Does not apply to Health Care FSA.

If you wish to change your elections due to a qualifying life event, you must notify the Plan Administrator within 30 calendar days of the qualifying life event by going online to *go.gwu.edu/easyenroll*. You must elect changes in accordance with procedures set forth by the Plan Administrator. Call GW Benefits at (571) 553-8382 for additional information.

Benefit elections or changes associated with birth/adoption events will be effective on the event date as long as you complete your online enrollment and provide supporting documentation validating the event within 60 calendar days from the event date. Benefit elections or changes received in connection with birth/adoption events after the 60 calendar days have expired will be effective prospectively, beginning on the first of the month following the date that the elections and supporting documents (whichever is later) are received.

Generally, benefit elections or changes associated with all other qualifying life events will be effective the first of the month following receipt of your supporting documentation – as long as you complete your online enrollment and submit your supporting documentation within 30 calendar days from the qualifying life event date, except in the case of a divorce/legal separation from your spouse, or the death of an eligible spouse or dependent, when you have 60 calendar days to change your elections.

When you make an approved election change that reduces your contributions, you may only reduce your total annual contributions to the amount of your year-to-date contributions at the time the election change is made.

Special Enrollment Rights Under HIPAA

If you decline to participate in the before-tax premium payment portion of the Plan because you have other health insurance coverage, you may later elect to participate in this portion if your other coverage terminates and you elect coverage under a university-sponsored group health plan. **You must elect to receive health benefits and enroll in the Before-Tax Premium Payment portion of the Plan within 30 calendar days of when your other coverage terminates, unless otherwise noted.** The university's Health and Welfare Benefit Plan/SPD discusses this and other special enrollment rights in more detail.

Cessation of Participation

Your participation in the Plan ends on the earliest of:

- the last day of the month in which you terminate employment;
- the last day of the month in which you are no longer eligible for the Plan or for benefits under the Plan;
- the last day of the month in which you fail to make required contributions under the Plan; or
- the date the Plan is terminated.

Notwithstanding the above, the Plan Administrator may, in its sole discretion, cause your participation in the Plan to terminate if you provide false information or make misrepresentations

in connection with a request for reimbursement, or obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions.

You and your dependents may be eligible for continuation coverage under COBRA after your participation in the Health Care FSA ends. **NOTE:** You have until the April 30 following the end of the Plan Year in which you terminate employment or otherwise become ineligible for participation in the Health Care FSA to submit claims for services incurred prior to your loss-of-coverage date. If you elect to continue Health Care FSA coverage through COBRA, your coverage remains effective through March 15 following the end of the Plan Year as long as you continue to make payments up to the end of the calendar year. Please see the section entitled "*Continuation of Health Care FSA Coverage - COBRA*" on page 24 for additional details. **Note that COBRA does not apply to the Dependent Care FSA.**

BEFORE-TAX PREMIUM PAYMENTS

Eligible employees who enroll in medical, dental and/or vision coverage under The George Washington University Health and Welfare Benefit Plan are automatically enrolled in the Before-Tax Premium Payment portion of the Plan. Under this portion of the Plan, you are permitted to contribute toward the applicable premiums of certain of the benefit options you chose with before-tax contributions. This means your premiums are withheld from your pay before Social Security taxes and federal income taxes are withheld (and in most states, state income tax as well).

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA)

Covering Eligible Health Care Expenses Using Your Health Care FSA

Expenses eligible for reimbursement through your Health Care FSA must be for yourself or for an eligible dependent. An eligible dependent for Health Care FSA purposes is a person you can legally claim as a dependent on your federal tax form. This includes:

- your spouse;
- your children ("children" includes a Participant's natural child, stepchild, foster child, adopted child or a child placed with the Participant for adoption) under age 26 without regard to student status, marital status, financial dependency or residency status with the Participant; and
- any other person who is considered to be a dependent by the Internal Revenue Service (IRS).

If you have a "domestic partner" or "civil union partner" whom you cannot claim as a dependent under IRS rules, then expenses for your domestic or civil union partner will not be eligible for reimbursement under the Health Care FSA.

Expenses eligible for reimbursement must also be incurred during your "period of coverage." This usually means the Plan Year, but if you terminate participation in the Health Care FSA prior to the last day of the Plan Year (for example, your employment with the university terminates), expenses incurred after your coverage ends (as described on page 9) do not qualify as eligible expenses for reimbursement. In addition, expenses incurred before your period of coverage began would not be eligible for reimbursement. The grace period for incurring expenses after the end of the Plan Year described below does not apply to an employee who terminates employment prior to the end of the Plan Year. See "*Cessation of Participation*" on page 9 for the rules relating to coverage when you terminate employment.

Note: If you elect COBRA continuation for your Health Care FSA, which is explained in the section "*Continuation of Health Care FSA Coverage – COBRA*," your period of coverage may be extended.

Your Contributions

Your Health Care FSA is funded by your before-tax contributions to the Plan. You may deposit a maximum of $2,700 (for Plan Year 2020), or a minimum of $100, per Plan Year into your Health Care FSA. After you choose a contribution amount, your contributions are deducted from your pay throughout the Plan Year on a before-tax basis. This means your contributions are withheld from your pay before Social Security taxes and federal income taxes are withheld (and in most states, state income tax as well). Later, when you apply for reimbursement from your account, no taxes are withheld or owed on the reimbursement – in other words, the reimbursement is tax-free.

How the Health Care FSA Works

Subject to an applicable grace period, qualifying health care expenses that are eligible for reimbursement must be incurred on or before the end of the Plan Year (or, if earlier, the end of your coverage). **All requests for reimbursement must be postmarked (or received by scan or facsimile) by April 30 of the following year.**

Use It or Lose It. The money you contribute to your Health Care FSA is available to reimburse you for eligible health care expenses that you incurred during your period of coverage and for which you have not otherwise received a reimbursement (see section "*Reimbursement Guidelines for the Health Care FSA*" on page 14). The IRS has set strict guidelines for these accounts because of the tax advantage. **You will forfeit any money left in your account after the reimbursement request deadline of April 30. Forfeited amounts will be returned to the university.** For this reason, you should carefully review your contribution amount each year and consider only eligible and predictable health care expenses when selecting a contribution amount.

The Health Care FSA contribution amount you elect for the Plan Year (less any reimbursements actually paid) is available at all times during your period of coverage under the Plan, regardless of the actual amount you have contributed to your account. For example, if you elect a $2,000 contribution and you incur $1,000 in qualifying expenses in February of the Plan Year, the $1,000 may be reimbursed in full even though you have not fully funded your Health Care FSA.

Grace Period: Qualifying health care expenses that are eligible for reimbursement must be incurred on or before the end of the applicable Plan Year (or, if earlier, the end of your coverage). However, the university has established a grace period that allows a two-and-one-half-month extension (from December 31 to March 15) of the period during which you may incur expenses if you had a balance remaining in your account at the end of the previous Plan Year and were a participant in the Plan on the last day of the previous Plan Year. This means, for example, that for the 2020 Plan Year, you may submit requests for reimbursement for qualifying expenses you incur on or before March 15, 2021. **All requests for reimbursement must be postmarked (or received by scan or facsimile) by April 30 following the end of the grace period (in our example, April 30, 2021).**

Additional rules apply to health care expenses incurred during the grace period. Expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding year and then from any amounts that are available to reimburse expenses incurred during the current year. Once paid, a reimbursement will not be reprocessed or otherwise re-characterized as to the year from which funds are taken to pay it. For this reason, you may want to wait to submit health care expenses for the new year until you are sure you have no remaining unreimbursed expenses from the prior year.

Reimbursement Guidelines for the Health Care FSA

Eligible Health Care FSA expenses are, in most cases, those that would qualify as deductions on your federal income tax return (if you were able to take a tax deduction for them). IRS Publication 502 summarizes types of expenses that are deductible. Following are examples of expenses that may be reimbursed through your Health Care FSA. For a complete list of eligible health care expenses, request Publication 502 from the IRS by accessing *www.irs.gov*. Keep in mind that IRS regulations may change from year to year. You may be reimbursed for over-the-counter drugs/medicines only if prescribed[2] by a doctor (with the exception of insulin). Examples of over-the-counter medicines requiring a prescription include those for indigestion and acid control, colds and flu, and pain relief. However, over-the-counter items that are NOT considered drugs/medicines are eligible without a prescription (such as bandages, arm/leg/back braces, crutches/mobility aids and contact lens supplies.

Qualifying Health Care Expense Examples	
Medical Care examples: • Birthing centers. • Blood, plasma, oxygen. • Hospital, surgical or medical treatment charges exceeding insurance reimbursement maximums. • Child health care expenses related to adoption (if incurred after adoption negotiations began). • Deductible, copayment and coinsurance expenses not paid under medical plan coverage. • Doctor's office or home visits.	Rehabilitation examples: • Physical therapy. • Prosthetic devices. • Special equipment. Hearing Care examples: • Audiometric exam. • Hearing aid batteries. • Hearing aid. • Hearing exam.

[2] A prescribed medicine means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

Qualifying Health Care Expense Examples	
Medical Care examples (cont.): • Experimental surgery. • Hospital room and board charges over the semiprivate room rate. • In vitro fertilization. • Intravenous transfusions. • Physical examinations. • Prescribed drugs. • Prescribed vitamins. • Private duty nursing care. • Syringes, needles and injections. • Transportation for treatment. • Treatment for substance abuse. • Treatment for mental health by a psychiatrist, psychologist or social worker. • Vaccinations.	Special Education Training examples: • Braille training. • Learning disability treatment. • Lip-reading training. • Sign language training. Vision Care examples: • Prescription glasses. • Contact lenses. • Eye exam by optometrist or ophthalmologist.

The following list includes examples of types of expenses that are not eligible for reimbursement under your Health Care FSA.

Examples of Expenses Not Eligible for Health Care FSA Reimbursement	
• Cosmetics. • Custodial care in an institution. • Certain long-term care expenses. • Health care premiums for other health care coverage. • Health club dues. • Meals. • Nonprescription items that are used for general health (such as vitamins and dietary supplements). • Over-the-counter medications other than insulin, if prescribed.	• Non-reconstructive cosmetic surgery. • Personal hygiene items such as toothpaste, shaving cream, deodorant and body lotion. • Weight-loss programs unless prescribed by a physician as treatment for a specific disease.

Federal Tax Deduction vs. Health Care FSA

You cannot be reimbursed from your Health Care FSA for health care expenses that you claim as tax deductions on your income tax return. Keep in mind that to deduct health care expenses on your tax return, your total unreimbursed expenses for the calendar year have to exceed 7.5 percent of your adjusted gross income. If you think your total out-of-pocket health care costs will reach that level, be sure to carefully consider which tax advantage would be better for you. You may wish to consult a tax advisor.

Qualified Reservist Distribution from a Health Care FSA

If you are called to active military duty for more than 179 calendar days or for an indefinite period, you may withdraw your unused Health Care FSA amounts without incurring eligible health care expenses. This special withdrawal provision applies from the date of the order or call to duty and ends on the April 30 following the applicable Plan Year. Withdrawals under this provision are subject to income tax withholding and reduce your Health Care FSA balance available for qualifying health care expenses.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DEPENDENT CARE FSA)

Covering Eligible Dependent Care Expenses Using Your Dependent Care FSA

Expenses eligible for reimbursement through your Dependent Care FSA must be for an eligible dependent who is a "qualifying individual." Qualifying individuals for Dependent Care FSA purposes include children under the age of 13 who are considered to be a dependent by the IRS (a child that you must be able to legally claim as a dependent on your federal income tax form) and a dependent or spouse who is physically or mentally incapable of caring for him/herself. This means, for example, if you have a domestic or civil union partner whom you cannot claim as a dependent under IRS rules, then your domestic or civil union partner (and your domestic or civil union partner's dependents) cannot be considered a qualifying individual under the Dependent Care FSA.

Expenses eligible for reimbursement must also be incurred during your "period of coverage." This usually means the Plan Year, but if you terminate participation in the Dependent Care FSA prior to the last day of the Plan Year (for example, your employment with the university terminates), you may still continue to request reimbursement for expenses incurred on or before December 31, up to your funded but unused Dependent Care FSA balance. Expenses incurred before your period of coverage began are not eligible for reimbursement. In the case of your leave of absence, expenses incurred on or after the first day of the month following the month in which the leave of absence begins are not eligible for reimbursement.

Your Contributions

Your Dependent Care FSA is funded by your before-tax contributions to the Plan. You may deposit a maximum of $5,000, or a minimum of $100, per Plan Year into your Dependent Care FSA. (If you are married and you and your spouse file separate tax returns, your maximum is $2,500.) After you choose a contribution amount, your contributions are deducted from your pay throughout the Plan Year on a before-tax basis. This means your contributions are withheld from your pay before Social Security taxes and federal income taxes are withheld (and in most states, state income tax as well). Later, when you apply for reimbursement from your account, no taxes are withheld or owed on the reimbursement – in other words, the reimbursement is tax-free.

If the Plan Administrator determines during any Plan Year that the Plan may not satisfy the applicable Internal Revenue Code requirements or limitations, the Plan Administrator may take any action deemed necessary to assure compliance. Such action may include, but is not limited to, reducing your contribution election without your consent if you are a highly compensated employee. How the Dependent Care FSA Works

Qualifying dependent care expenses that are eligible for reimbursement must be incurred on or before the end of the Plan Year. **All requests for reimbursement must be postmarked (or received by scan or facsimile) by April 30 of the following year.**

Use It or Lose It. The money you contribute to your Dependent Care FSA is available to reimburse you for eligible dependent care expenses that you incurred during the Plan Year and for which you have not otherwise received a reimbursement (see section titled "*Reimbursement Guidelines for the Dependent Care FSA*" on page 18). The Internal Revenue Service has set

strict guidelines for these accounts because of the tax advantage. **You will forfeit any money left in your account after the reimbursement request deadline of April 30. Forfeited amounts will be returned to the university.** For this reason, you should be conservative in determining your contribution amount each year and use only eligible and predictable dependent care expenses when selecting a contribution amount.

Reimbursement Guidelines for the Dependent Care FSA

Eligible Dependent Care FSA expenses are "qualifying dependent care expenses," which are those dependent care expenses that are incurred to enable you to be gainfully employed. If you are married, your spouse must also work, be a full-time student[3] or be disabled. Following are examples of expenses that may be reimbursed through your Dependent Care FSA. For a complete list of eligible dependent care expenses, request Publication 503 from the IRS by accessing *www.irs.gov*.

Qualifying Dependent Care Expense Examples	
• Pre-school, day camp, care before or after school and adult day care. • Day care in your home or someone else's home as long as the caregiver is not your spouse, your dependent or your own child under the age of 19. • A housekeeper whose duties include watching your children or disabled relatives while you work.	• A licensed child care or adult care center that meets all state and local regulations. A day care center is defined as any facility that provides full-time or part-time care for more than six individuals on a regular basis during the year and receives a fee, payment or grant for providing such services to any individual regardless of whether or not the facility is operated for a profit.

The following list includes examples of types of expenses not eligible for reimbursement under your Dependent Care FSA:

Expenses Not Eligible for Dependent Care FSA Reimbursement	
• Unlicensed day care or adult care centers. • Care provided by a facility that does not provide full-time or part-time care for more than six individuals on a regular basis during the year. • Care provided by your spouse or another person you can claim as a dependent for income tax purposes.	• Kindergarten that is primarily educational in nature. • Overnight camp. • Babysitters for times when you are not at work. • Nursing homes or institutions if the disabled dependent lives there instead of in your home.

[3]If your spouse is a full-time student, under IRS guidelines certain income assumptions are made that may affect the amount you may contribute for qualified dependent care expenses. Contact GW Benefits for further details.

Federal Tax Credit for Dependent Care vs. Dependent Care FSA

The federal tax credit for dependent care expenses allows a percentage of your annual eligible work-related dependent care expenses to be claimed as a credit against your federal income tax liability. Whether the tax credit or participation in the Dependent Care FSA is better for you depends on a number of factors such as your tax filing status, your number of dependents, your income tax bracket and other tax-related factors. You should consult a tax advisor if you have any questions about your specific situation.

REQUESTS FOR REIMBURSEMENT

Filing a Request for Reimbursement

The university has contracted with PayFlex Systems USA, Inc., a third party administrator, to administer the Health Care FSA and the Dependent Care FSA. In order to request reimbursement for expenses from the Health Care FSA or the Dependent Care FSA, you must complete a PayFlex Health/Dependent Care Flexible Spending Accounts Claim Form, attach the appropriate documentation (noted on the form) and submit it to the following address:

PayFlex Systems USA, Inc.
Post Office Box 3039
Omaha, NE 68103-3039

You can obtain claim forms from PayFlex through the Internet at www.payflex.com or by calling PayFlex at (800) 284-4885 (Monday through Friday from 7:00 a.m. to 7:00 p.m., Central Time, or Saturday from 9:00 a.m. to 2:00 p.m., Central Time). In addition, you can call the university's Benefits Call Center at (888) 4GWUBEN (449-8236), Monday through Friday, 9:00 a.m. to 6:00 p.m., Eastern Time.

Debit Card

PayFlex will issue you a debit card if you enroll in the Health Care FSA, the Dependent Care FSA or both. You can use the debit card to pay for your eligible expenses as you incur them. **WHEN YOU USE THE DEBIT CARD, YOU MUST ALWAYS SAVE YOUR RECEIPTS IN CASE ADDITIONAL DOCUMENTATION IS REQUESTED**. In addition, the following rules apply:

- You will be able to use your debit card for eligible dependent care services provided by day care providers using Merchant Category Code (MCC) 8211.
- You will be able to use your debit card for eligible health care services at medical care providers. You are also able to use your debit card at drug stores and pharmacies validated through the Inventory Information Approval System approved by the Internal Revenue Service.
- When you use your debit card for eligible health care services, be sure to purchase eligible items separate from non-eligible items.
- You must respond when asked to substantiate the use of your debit card with proper receipts. Failure to respond in a timely manner requires the deactivation of your debit card, and will result in taxable income to you in the amount of the unsubstantiated claim.
- If your debit card is not accepted, pay for the eligible expense and file a reimbursement request as explained above.

You may contact PayFlex at (800) 284-4885 to obtain a list of approved vendors.

CLAIM REVIEW AND APPEAL PROCEDURES

Plan Eligibility Determinations

The Plan Administrator or the Plan Administrator's delegate makes determinations regarding eligibility for benefits under the Plan, such as whether an employee or former employee has properly and timely enrolled in coverage for himself or herself and any Dependents, whether a participant is entitled to change enrollment mid-year, and whether a requested mid-year change is consistent with the event that triggered the change, among others. In the event of an adverse determination, including a denial, reduction, or termination of coverage based on a determination regarding an individual's eligibility to participate in the Plan, the determination may be appealed by contacting GW Benefits.

Claims for Benefits

These claim review and appeal procedures apply to claims for benefits under the Plan.

A "claim" is a request for benefits that is filed by a Plan Particpant or beneficiary or his or her authorized prepresentative in accordance with the applicable claims proceudres. A request to determinate eligibility under the Plan is not a "claim" under the rules set forth here under the heading *Claims for Benefits*. A casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined by the Claims Administrator that your inquiry is an attempt to file a claim.

In general, claims must be filed in writing with the Claims Administrator. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice identifying such authorized representative. You must submit all initial claims under the Plan no later than April 30 following the Plan Year in which the claim occurred.

For purposes of this section, PayFlex, (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company), is referred to as the "Claims Administrator." Please see the section *"Requests for Reimbursement"* on page 20 for the name and address of the Claims Administrator.

You will note that, consistent with the applicable regulations, time periods for processing Health Care FSA claims are generally shorter than time periods for processing Dependent Care FSA claims.

Time Periods for Responding to Initial Claims: If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your Health Care FSA claim within 30 calendar days and/or your Dependent Care FSA claim within 90 calendar days, after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day or 90-day period, as applicable, that the Claims Administrator needs up to an additional 15 calendar days to review your Health Care FSA claim or up to an additional 90 calendar days to review your

Dependent Care FSA claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 calendar days from the date you receive the notice to provide the requested information.

Notice and Information Contained in Notice Denying Initial Claim. If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:

- *Reason for the Denial* – the specific reason or reasons for the denial.
- *Reference to Plan Provisions* – reference to the specific Plan provisions on which the denial is based.
- *Description of Additional Material* – a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary.
- *Description of Any Internal Rules* – for Health Care FSA claims, a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request.
- *Description of Claims Appeals Procedures* – a description of the Plan's appeals procedures and the time limits applicable for such procedures (including a statement that you are eligible to bring a civil action in federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

Appealing a Denied Claim for Benefits: If the Claims Administrator denies your initial Health Care FSA claim for benefits, you may appeal the denial by filing an oral or written request with the Claims Administrator within 180 calendar days after you receive the notice of denial. If the Claims Administrator denies your initial Dependent Care FSA claim for benefits, you may appeal the denial by filing an oral or written request with the Claims Administrator within 60 calendar days after you receive the notice of denial. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Claims Administrator, for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims. If you appeal a denied claim for benefits under the Health Care FSA or the Dependent Care FSA, you will receive a response within 60 calendar days after receipt of the appeal.

Notice and Information Contained in Notice Denying Appeal. If the Claims Administrator denies your claim (in whole or in part), then the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- *Reason for the Denial* – the specific reason or reasons for the denial.
- *Reference to Plan Provisions* – reference to the specific Plan provisions on which the denial is based.
- *Statement of Entitlement to Documents* – a statement that you are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information that is relevant to your claim and/or appeal for benefits.
- *Description of Any Internal Rules* – for Health Care FSA claims, a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request.
- *Statement of Right to Bring Action* – a statement that you are entitled to bring a civil action in federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Claims Administrator is final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. This appeal process must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after exhausting the appeals procedure may be submitted for reconsideration of the appeal within the time limits described above. Issues not raised during the appeal will be deemed waived. If you challenge the final decision of the Claims Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above.

Time Limit on Legal Proceedings

After exhausting the Plan's administrative claim process described above, a claimant may file a lawsuit regarding entitlement to benefits. Any such legal action must be commenced within one year from the time that a Plan eligibility determination appeal or benefit claim appeal is denied (unless otherwise prescribed by applicable law).

CONTINUATION OF HEALTH CARE FSA COVERAGE – COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that has several provisions designed to protect you and your family against a sudden loss of health care coverage if you have a "qualifying event" (explained below) that would cause the termination of your Health Care FSA participation. The following information outlines the continuation of coverage available under COBRA **for your Health Care FSA only**. (Dependent Care FSA benefits are not eligible for COBRA election.)

Explanation of COBRA Continuation Coverage

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

Individuals who are eligible for COBRA coverage are called "qualified beneficiaries." The events that entitle them to coverage are called "qualifying events." To be a qualified beneficiary for a specific type of health coverage, you must have had that particular coverage under the Plan on the day before a qualifying event occurs.

Qualifying events include a loss of Health Care FSA coverage due to a reduction in your hours of employment, termination of your employment (for reasons other than gross misconduct), your divorce or legal separation and your entitlement to Medicare. Your dependent's qualifying events include a loss of Health Care FSA coverage due to the death of a parent, divorce or legal separation and the dependent's ceasing to be a dependent under the Plan.

Who Must Provide Notice When Coverage is Lost

When a qualifying event occurs, you and the university have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, **you or a covered family member must notify the Plan Administrator in writing within 60 calendar days of the qualifying event**. Failure to timely notify the Plan Administrator will result in a reduction or loss of the qualified beneficiary's COBRA entitlement. The university must know if the event is death, termination of employment, reduction in hours or entitlement to Medicare benefits.

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

If You Elect to Continue Coverage

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

If you elect to continue your medical coverage, you must pay a total premium equal to your contributions plus the university's contribution, plus a two percent (2%) monthly administration charge (or such higher charge as may be permitted by law). If you wish to continue your Health Care FSA, you must timely submit your contributions on a post-tax basis plus a two percent (2%) monthly administrative charge. Please contact PayFlex for more information on premium costs at (800) 284-4885.

Website: www.payflex.com

Written inquiries can be sent to:

PayFlex Systems USA, Inc.
Benefit Billing Department
Post Office Box 2239
Omaha, NE 68103

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

Limitations on a COBRA Election

COBRA continuation coverage is available under the Health Care FSA due to a qualifying event, but subject to the following limitations.

Generally, if you participate in the Health Care FSA, you will be entitled to elect continuation coverage only if you can receive some economic benefit from that election. COBRA continuation coverage may only be elected for your Health Care FSA if, as of the date of the event, the maximum benefit available under the Health Care FSA for the remainder of the Plan Year is more than the maximum amount that the Health Care FSA could require as payment to maintain coverage under the Health Care FSA of that Plan Year.

For example, if you made a before-tax election to have a $100 contribution to your Health Care FSA and you have already been reimbursed that amount as of the event that causes you to lose coverage, you will not have the right to make a COBRA election with respect to the Health Care FSA. In addition, you generally will not have COBRA rights under the Health Care FSA if the premiums you will pay for the remainder of the Plan Year under COBRA will exceed the amount you could be reimbursed. For example, if you assume the same $100 example, but that you had been paid $70 from your Health Care FSA through your COBRA election date, you would still be entitled to a $30 reimbursement under the Health Care FSA. If your COBRA premiums for the remainder of that Plan Year would exceed $30, you would not be entitled to elect continuation coverage under the Health Care FSA.

When COBRA Benefits End

You may elect COBRA coverage for the rest of the Plan Year in which the qualifying event takes place. However, COBRA benefits will end immediately if the person whose coverage is being continued fails to pay the premium on time. COBRA continuation coverage is not offered under the Health Care FSA for years that follow the Plan Year in which the event causing the loss of coverage occurs.

PLAN ADMINISTRATOR

The Plan Administrator for the Plan is the Plan Administration Committee. The name, business address and business telephone number of the Plan Administrator are provided under the section "*Additional Information*" below.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated the authority to administer reimbursement requests and benefit claims appeals for the Health Care FSA and the Dependent Care FSA to PayFlex.

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

PLAN AMENDMENT OR TERMINATION

The university (acting through the Executive Vice President and Chief Financial Officer or his delegate) reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their dependents. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease employee contributions, (3) change the class(es) of employees and/or dependents covered by the Plan and (4) change providers. The university may also make certain administrative changes to the Plan and amendments to the benefits provided under the Plan. The university also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination or partial termination.

ADDITIONAL INFORMATION

Plan Name	The George Washington University Flexible Benefits Plan
Plan Sponsor	The George Washington University 45155 Research Place, Suite 160 Ashburn, VA 20147 (571) 553-8382
Plan Administrator	Plan Administration Committee The George Washington University 45155 Research Place, Suite 160 Ashburn, VA 20147 (571) 553-8324
Employer Identification Number	53-0196584
Plan Number	512
Plan Year	January 1 through December 31
Type of Plan	The Plan is a welfare plan providing premium conversion and health and dependent care reimbursement.
Administration and Funding	The Plan is self-insured. Benefits are paid out of the general assets of the university and administered in accordance with a contract between the university and PayFlex Systems USA, Inc.
Agent to Receive Legal Process	Mary Lynn Reed Senior Counsel The George Washington University 2100 Pennsylvania Avenue, NW, Suite 250 Washington, DC 20052
Plan Contributions	Contributions are paid by Plan participants.
Service Provider Contact Information	PayFlex Systems USA, Inc. P.O. Box 953374 St. Louis, MO 63195-3374 800-284-4885 www.payflex.com

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an 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. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Health Care FSA Coverage

Continue Health Care FSA coverage for yourself, your spouse 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 this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 calendar days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or

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

Assistance with Your Questions

If you have any questions about your Health Care FSA and/or Dependent Care FSA Plan, you should contact PayFlex. If you have questions about your Before-Tax Premium Payment Plans, please contact GW Benefits. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.

HEALTH SAVINGS ACCOUNT PROGRAM (HSA)

A Health Savings Account ("HSA") is a personal tax-exempt account established with an HSA trustee that allows you to save and pay for eligible medical care expenses tax-free. The university has selected PayFlex administer the HSA Program available for university employees and BNY Mellon is the trustee. You also have the option to establish an HSA and make contributions outside of the university's program.

The information provided here is general and you should read the PayFlex brochure titled "HSA Road Rules" and IRS Publication 969 for more detailed information.

The HSA Program is not an ERISA-covered plan. Therefore, the portions of this document which relate only to ERISA-covered plans (such as the claims information and election change restrictions) do not apply to the HSA Program.

Eligibility for HSA

To be eligible to make contributions to the HSA Program offered by the university, you must be covered by the high deductible health plan ("HDHP") medical coverage under the university's Health and Welfare Benefit Plan (which is the GW Health Savings Plan ("HSP") option), and you cannot be:

- covered under any other medical plan that is not an HDHP;
- covered by a Health Care FSA;
- entitled to Medicare, Medicaid or TRICARE benefits; or
- claimed as another person's tax dependent.

The IRS defines an HDHP as a health plan with minimum deductible amounts and maximum out-of-pocket amounts. The table below shows the 2019 and 2020 requirements. The IRS may adjust these amounts each year for inflation.

	2019/2020 High Deductible Health Plan (HDHP) Requirements	
HDHP Coverage Tier	**Minimum Deductible**	**Maximum out-of-pocket expenses**
Individual coverage	$1,350/$1,400	$6,750/$6,900
Any coverage tier other than individual coverage	$2,700/$2,800	$13,500/$13,800

It is your responsibility to understand the IRS rules regarding whether you are in fact eligible to participate in an HSA and the tax consequences of HSA contributions and distributions. More information is available from IRS Publication 969. You may also want to consult your tax advisor for further information.

HSA Contributions

You may make contributions on a pre-tax basis through payroll deduction to your HSA up to an annual limit established by the IRS. You decide how to invest your account and any investment earnings on the account accumulate tax-free. Your election to contribute to your HSA can be increased, decreased, or revoked at any time on a prospective basis by contacting PayFlex. No benefit election changes can occur as a result of a change in your HSA election. For example, you may not terminate your Health Care FSA in order to begin contributing to an HSA, unless you have also had a qualifying life event (see *"Enrollment and Election Changes"* on page 7).

The university may make discretionary contributions to this HSA Program for certain eligible employees. In any year that the university makes an HSA contribution, the entire amount will be deposited to the eligible employee's account coincident with their first full pay period contribution. If the eligible employee terminates employment before their first full pay period contribution of the Plan Year (generally coincident with the first pay date of the Plan Year), the university will contribute a 100% match, of the amount the eligible employee contributed to the HSA in the final paycheck, up to the annual limit. Contact GW Benefits at (571) 553-8382 for additional information.

Although the university has selected PayFlex and BNY Mellon as its HSA providers, you may also establish an HSA with another qualified financial institution; however, the university is unable to facilitate a payroll deduction for your contributions and will not make any discretionary university contributions to the HSA.

HSA Benefits and Claims

The terms and conditions of coverage and benefits are set by PayFlex and BNY Mellon, and not by this Plan or any other plan sponsored by the university. With PayFlex, you can use an HSA debit card for convenient payment from your HSA for eligible medical care expenses. All claims are subject to verification.