

THE GEORGE WASHINGTON UNIVERSITY

SUMMARY PLAN DESCRIPTION

for the

FLEXIBLE BENEFITS ACCOUNT CAFETERIA PLAN

including the

Health Care Flexible Spending Account Plan

and the

Dependent Care Flexible Spending Account Plan

Effective date: January 1, 2005

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INTRODUCTION

The George Washington University (the “University”) sponsors the George Washington University Flexible Benefits Account Cafeteria Plan (the “Plan”), which includes the George Washington University Health Care Flexible Spending Account Plan, and the George Washington University Dependent Care Flexible Spending Account Plan, to allow its eligible employees to (i) contribute toward health and dental insurance premiums using before-tax money, and (ii) to set aside money on a before-tax basis in order to reimburse themselves for medical expenses or dependent care.

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

You can review the Plan documents and other documents concerning the Plan during regular business hours or by appointment at a mutually convenient time at the University’s Benefit Services Division. You may obtain copies of the documents constituting the Plan and of certain reports by contacting the University’s Benefit Services Division at (202) 994-9620 (a reasonable charge may be imposed for those copies, as permitted by federal regulation).

The Plan Administrator has the discretionary authority to interpret the Plan provisions and apply them to specific situations, and benefits will be 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 (202) 994-9620 if you have questions about this booklet, the Plan, or any other Plan materials.

ELIGIBILITY TO PARTICIPATE

Employees Eligible for Participation

The following employees are eligible for participation in the Plan upon meeting the applicable service requirements described in the “ENROLLMENT” section below.

- employees who work at least 14 hours per week; or
- employees eligible for the provisions of the Family and Medical Leave Act of 1993 (“FMLA”). Please contact the University’s Benefit Services Division at (202) 994-9620 for information regarding payment of premiums while on approved leave of absence.

Individuals Not Eligible for Participation

The following individuals are not eligible to participate in the Plan:

- individuals classified by the University as a “leased employees;”
- individuals classified by the University as temporary employees, independent contractors, contract workers, casual employees or consultants regardless of how long each such individual actually works for the University;
- individuals classified by the University as students of the University including fellows, graduate teaching assistants, or other individuals whose duties are incidental to their education programs; or
- non-resident aliens with no U.S. source income.

ENROLLMENT

Initial Enrollment

You will be eligible for the Health Care Flexible Spending Account (“Health Care FSA”) and the Dependent Care Flexible Spending Account (“Dependent Care FSA”) as of your 91st day of employment. You may enroll by completing the required enrollment forms, which are available on-line at the University’s HRS website at www.gwu.edu/hrs/forms, or you can request them by contacting the University’s Benefit Services Division at (202) 994-9620. Completed forms should be returned the University’s Benefit Services Division no later than 30 days prior to your 91st day of employment.

If you do not complete and return the enrollment forms for the Health Care FSA and the Dependent Care FSA by the deadline, you will not be able to enroll until the next open enrollment period.

Open Enrollment

During each annual open enrollment period, you will be given 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 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.**

Changes to Enrollment Election

Generally, you may not make changes to your Health Care FSA and Dependent Care FSA elections during the plan year, but you may change your elections during the plan year if you have a “change in status.” Your election change must be consistent with the change in status, and you must notify the Plan Administrator within 30 days of the change. The chart below lists events considered to cause a change in status.

Health Care FSA

- Marriage, death of spouse, divorce, legal separation, annulment.
- Birth, adoption, or death of dependent (as “dependent” is defined under the “*Covering Eligible Health Care Expenses With Your Health Care FSA*” section on page 4).
- Change in your or a 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 require health coverage for your child.
- Entitlement to Medicare or Medicaid.

Dependent Care FSA

- Marriage, death of spouse, divorce, legal separation, annulment.
- Birth, adoption, or death of dependent (as “dependent” is defined under the “*Covering Eligible Dependent Care Expenses With Your Dependent Care FSA*” section on page 6).
- Change in your or a 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 require health coverage for your child.
- Significant cost change (increase or decrease) imposed by a dependent care provider.

If you wish to change your elections due to a change in status, you must notify the Plan Administrator within 30 days of the change in status event by submitting the appropriate form to the University’s Benefit Services Division. Your election will be changed effective as of the first day of the month beginning after the date your completed request for the election change is received; provided, however, in the case of the birth, adoption, or placement for adoption of a new Dependent, your change in coverage will be retroactive to the date of such event *as long as you notify the Plan Administrator within 30 days of the event.*

Cessation of Participation

Your participation in the Plan ends on the earliest of:

- the date the Plan is terminated;

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

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 claim for benefits; or obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions.

The University may continue coverage during certain periods of absence, such as a leave of absence under FMLA, in accordance with its written personnel policies and practices. The University may require contributions during periods of absence in accordance with its written personnel policies and practices. Please contact the University’s Benefit Services Division at (202) 994-9620 for more information about coverage during an approved leave of absence.

You and your dependents may be eligible for continuation coverage under COBRA after your participation in the Health Care FSA ends. Please see the section entitled “CONTINUATION OF HEALTH CARE FSA COVERAGE - - COBRA” on page 9 for details. Note that COBRA does not apply to the Dependent Care FSA.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Covering Eligible Health Care Expenses With Your Health Care FSA

Expenses eligible for reimbursement through your Health Care FSA must be for yourself or for an eligible dependent. Eligible dependents for Health Care FSA purposes include your spouse, children, and any other person who is considered to be a dependent by the IRS. In other words, a person you can legally claim as a dependent on your federal income tax form is considered an eligible dependent. This means, for example, that if you have a “domestic partner” but your domestic partner cannot be claimed by you as a dependent under IRS rules, then expenses for your domestic partner will not be eligible for reimbursement under the Health Care FSA.

Your Contributions

The Plan is funded completely by employee contributions (you will be required to make contributions in order to participate in this Plan). You may deposit up to \$5,000 annually into your Health Care FSA (\$2,500 if you are married and you and spouse file separate tax returns). After you choose an amount, your contributions will be deducted automatically from your pay throughout the year on a before tax basis. This means your contributions will be withheld from your pay before Social Security taxes and federal income taxes are calculated and withheld (and in most states, state income tax as well). Later, when you apply for reimbursement from your account, there will be no taxes withheld or owed on that money - - in other words, the money is tax-free (except in those states that impose income tax on this money).

How the Health Care FSA Works

The money that you contribute to your Health Care FSA will be used by you during the plan year to reimburse yourself for eligible, unreimbursed health care expenses (see section titled,

“*Reimbursement Guidelines for the Health Care FSA*” on page 5) after being incurred by you. The Internal Revenue Service has set strict guidelines for these accounts because of the tax advantage. You may submit claims for reimbursement up to March 31 of the following year only for expenses you incurred through December 31 of the previous year. **After that, the previous plan year will be closed for reimbursements and you will forfeit any money left in your account.** If your participation ends prior to the end of the current year, you may only request reimbursement for expenses incurred up to your last day of participation (including participation under COBRA, if applicable).

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). Internal Revenue Service Publication 502 summarizes types of expenses that are deductible. Following are examples of expenses that may be reimbursed through your Health Care FSA.

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.
- Experimental surgery.
- Hospital room and board charges over the semi-private room rate.
- In vitro fertilization.
- Intravenous transfusions.
- Certain non-prescription medicines and drugs used for medical care.
- 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.

Rehabilitation examples:

- Physical therapy.
- Prosthetic devices.
- Special equipment.

Hearing Care examples:

- Audiometric exam.
- Hearing aid batteries.
- Hearing aid.
- Hearing exam.

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 not eligible for reimbursement under your Health Care FSA.

Ineligible Expense Examples:

- Cosmetics.
- Custodial care in an institution.
- Certain long-term care expenses.
- Health care premiums for other health care coverage.
- Health club dues.
- Marriage or family counseling.
- Meals.
- Non-prescription items such as vitamins, and dietary supplements that are beneficial for general health.
- Non-reconstructive cosmetic surgery.

Federal Tax Deduction vs. Health Care FSA

You cannot be reimbursed for health care expenses from your Health Care FSA for 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 that 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.

DEPENDENT CARE FLEXIBLE ACCOUNT PLAN

Covering Eligible Dependent Care Expenses With 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, that if you have a “domestic partner” but your domestic partner (and domestic partner’s dependents) cannot be claimed by you as a dependent under IRS rules, then your domestic partner (including your domestic partner’s dependents) can not be considered a qualifying individual under the Dependent Care FSA.

Your Contributions

The Plan is funded completely by employee contributions (you will be required to make contributions in order to participate in this Plan). You may deposit up to \$5,000 annually into your Health Care FSA (\$2,500 if you are married and you and spouse file separate tax returns). After you choose an amount, your contributions will be deducted automatically from your pay throughout the year on a before tax basis. This means your contributions will be withheld from your pay before Social Security taxes and federal income taxes are (and in most states, state income tax as well). Later, when you apply for reimbursement from your account, there will be no taxes withheld or owed on that money - - in other words, the money is tax-free (except in those states that impose income tax on this money).

How the Dependent Care FSA Works

The money that you contribute to your Dependent Care FSA will be used by you during the plan year to reimburse yourself for eligible, dependent care expenses (see section titled, “*Reimbursement Guidelines for the Dependent Care FSA*” below) after they are incurred by you. The Internal Revenue Service has set strict guidelines for these accounts because of the tax advantage. You may submit claims for reimbursement up to March 31 of the following year only for expenses you incurred through December 31 of the previous year. **After that, the previous plan year will be closed for reimbursements and you will forfeit any money left in your account.** If your participation ends prior to the end of the current year, you may only request reimbursement for expenses incurred up to your last day of participation (including participation under COBRA, if applicable).

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 because of your employment. That is, these expenses enable you to be gainfully employed. Following are examples of expenses that may be reimbursed through your Dependent Care FSA.

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.

Federal Tax Credit for Dependent Care vs. Dependent Care FSA

The federal tax credit for dependent care 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.

PRE-TAX PREMIUMS CONVERSION

Eligible employees who enroll in coverage under the George Washington University Health Insurance Plan and the George Washington University Dental Insurance Plan will contribute toward the applicable premiums with before-tax contributions. This means that your contributions will be withheld from your pay before social security taxes, federal income taxes, and in most states, state income tax as well, are calculated and withheld from your pay.

CLAIMS AND APPEAL PROCEDURES

Filing a Claim for Reimbursement

The University has contracted with a “third party administrator,” Hirsch Financial Services (“HFS”), 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 claim form, attach the appropriate documentation (noted on the claim form), and submit your claim to HFS at the following address:

Hirsch Financial Services
164 Lakefront Drive
Hunt Valley, MD 21030

You can obtain claims forms from HFS through the internet at www.hfsbenefits.com, or by calling HFS at (888) 460-8005 (Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time). In addition, you can call the University’s Benefit Services Division at (202) 994-9620.

Claim Denials

If your claim for benefits from the Health Care FSA or the Dependent Care FSA is denied, in whole or in part, you will receive written notification from HFS within a reasonable period of time, but not later than 30 days (which can be extended for up to an additional 15 days, with notice to you) after receipt of your request for reimbursement.

The notice of denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

- a description of the review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

Appeal Procedure

If a claim is denied you have the right to appeal the denial. You must file your appeal within 180 days of your receipt of the initial claim denial, and you may send your appeal to:

Hirsch Financial Services
164 Lakefront Drive
Hunt Valley, MD 21030

The Plan Administrator will respond to your appeal within 60 days of receipt of your appeal.

Legal Actions

Any lawsuit by you against the Plan Administrator must be commenced within 12 months from the date of the Plan Administrator's decision on appeal. Before you may bring a lawsuit, you or your Dependent must first exhaust the Plan's appeal procedure as described above.

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).

Explanation of COBRA Continuation Coverage

COBRA requires most employers that sponsor group health care plans (including health care spending account plans) 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 which 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.

Who Must Provide Notice When Coverage is Lost

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

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

If You Elect to Continue Coverage

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

If you elect to continue coverage, you must pay a total premium equal to your contributions prior to the qualifying event, plus a two percent (2%) monthly administration charge (or such higher charge as may be permitted by law. Please contact the University for more information on premium cost.

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

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.

PLAN ADMINISTRATOR

The Plan Administrator for the Plan is the University. The name, business address, and business telephone number of the University are provided under the section entitled “ADDITIONAL INFORMATION” on page 11.

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 benefit claims under the Plan to Hirsch Financial Services.

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

PLAN AMENDMENT OR TERMINATION

The University reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees 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 Sponsor and Plan Administrator	The George Washington University 2121 Eye Street, NW Washington, DC 20052
Employer Identification Number	53-0196584
Plan Names	The George Washington University Flexible Benefit Accounts Cafeteria Plan
Plan Identification Number	512
Plan Year	January 1 – December 31
Type of Plan	The Plan is a welfare plan providing premium conversion, and medical and dependent care reimbursement.

Claims Administration and Funding

The Plan is self-insured. Benefit claims are paid out of the general assets of the University and administered in accordance with a contract between the University and Hirsch Financial Services, Inc. (164 Lakefront Drive, Hunt Valley, Maryland 21030)

Agent for Service of Legal Process

The George Washington University
2100 Pennsylvania Avenue, NW
Suite 250
Washington, DC 20052
ATTN: Dennis H. Blumer
Vice President and General Counsel

Plan Contributions

Contributions are paid Plan participants.

LOSS OF BENEFITS

Except as might otherwise be described in this booklet, or other Plan booklets, your coverage ends when your employment with the University terminates (unless you are covered by the Plan as a retiree). This will occur upon your retirement, resignation, discharge, or death. The University will, however, discuss with you at your request what, if any, arrangements may be made to continue coverage beyond the date your employment ceases. The section entitled “CONTINUATION OF HEALTH CARE FSA COVERAGE - - COBRA” on page 9 also describes certain circumstances under which health care coverage may be continued after the date your employment ends, or, in the case of your Dependents, after the date on which they become ineligible for health care coverage under the Plan.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

summary plan description. The 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 coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If

you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact . If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FOR YOUR REFERENCE

- HFS Customer Services Representatives are available to answer inquires, and for forms requests, Monday through Friday from 8:00 a.m. until 5:00 p.m., Eastern Time (ET) for claims status and claim form requests. Please contact Customer Service at (888) 460-8005.
- You can also send written inquiries regarding your FSA benefits to:

Hirsch Financial Services
Customer Services
164 Lakefront Drive
Hunt Valley, MD 21030
- For other inquiries regarding your FSA benefits, you may contact the University's Benefit Services Division at (202) 994-9620.
- You may also send inquiries to:

The George Washington University
Human Resource Services, Benefit Services Division
Suite 220
2033 K Street, NW
Washington, DC 20052