THE GEORGE WASHINGTON UNIVERSITY

FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2013
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>ELIGIBILITY TO PARTICIPATE</td>
<td>2</td>
</tr>
<tr>
<td>- Employees Eligible for Participation</td>
<td>2</td>
</tr>
<tr>
<td>- Individuals Not Eligible for Participation</td>
<td>2</td>
</tr>
<tr>
<td>- Participation During a Leave of Absence</td>
<td>2</td>
</tr>
<tr>
<td>ENROLLMENT AND ELECTION CHANGES</td>
<td>4</td>
</tr>
<tr>
<td>- Initial Enrollment</td>
<td>4</td>
</tr>
<tr>
<td>- Re-Enrollment</td>
<td>4</td>
</tr>
<tr>
<td>- Open Enrollment</td>
<td>4</td>
</tr>
<tr>
<td>- Changes to Enrollment Election</td>
<td>4</td>
</tr>
<tr>
<td>- Special Enrollment Rights Under HIPAA</td>
<td>5</td>
</tr>
<tr>
<td>- Cessation of Participation</td>
<td>6</td>
</tr>
<tr>
<td>BEFORE-TAX PREMIUM PAYMENTS</td>
<td>7</td>
</tr>
<tr>
<td>HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA)</td>
<td>8</td>
</tr>
<tr>
<td>- Covering Eligible Health Care Expenses Using Your Health Care FSA</td>
<td>8</td>
</tr>
<tr>
<td>- Your Contributions</td>
<td>8</td>
</tr>
<tr>
<td>- How the Health Care FSA Works</td>
<td>8</td>
</tr>
<tr>
<td>- Reimbursement Guidelines for the Health Care FSA</td>
<td>10</td>
</tr>
<tr>
<td>- Federal Tax Deduction vs. Health Care FSA</td>
<td>12</td>
</tr>
<tr>
<td>- Qualified Reservist Distribution from a Health Care FSA</td>
<td>12</td>
</tr>
<tr>
<td>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DEPENDENT CARE FSA)</td>
<td>13</td>
</tr>
<tr>
<td>- Covering Eligible Dependent Care Expenses Using Your Dependent Care FSA</td>
<td>13</td>
</tr>
<tr>
<td>- Your Contributions</td>
<td>13</td>
</tr>
<tr>
<td>- How the Dependent Care FSA Works</td>
<td>13</td>
</tr>
<tr>
<td>- Reimbursement Guidelines for the Dependent Care FSA</td>
<td>14</td>
</tr>
<tr>
<td>- Federal Tax Credit for Dependent Care vs. Dependent Care FSA</td>
<td>15</td>
</tr>
<tr>
<td>REQUESTS FOR REIMBURSEMENT</td>
<td>16</td>
</tr>
<tr>
<td>- Filing a Request for Reimbursement</td>
<td>16</td>
</tr>
<tr>
<td>- Debit Card</td>
<td>16</td>
</tr>
<tr>
<td>CLAIM REVIEW AND APPEAL PROCEDURES</td>
<td>17</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS
(continued)

CONTINUATION OF HEALTH CARE FSA COVERAGE – COBRA ......................... 20
  Explanation of COBRA Continuation Coverage ........................................ 20
  Who Must Provide Notice When Coverage is Lost .................................. 20
  If You Elect to Continue Coverage ............................................................ 20
  Limitations on a COBRA Election ............................................................... 21
  When COBRA Benefits End .................................................................... 21

PLAN ADMINISTRATOR .................................................................................. 22

PLAN AMENDMENT OR TERMINATION ......................................................... 23

ADDITIONAL INFORMATION .......................................................................... 24

STATEMENT OF ERISA RIGHTS ................................................................. 25
  Receive Information About Your Plan and Benefits .................................. 25
  Continue Health Care FSA Coverage ....................................................... 25
  Prudent Actions by Plan Fiduciaries .......................................................... 25
  Enforce Your Rights .................................................................................. 25
  Assistance with Your Questions .............................................................. 26
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 insurance 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 booklet:

- Before-Tax Health, Vision and Dental Insurance 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 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 document. **If there is any conflict between this booklet and the Plan document, the Plan document will control.**

You can review the Plan document and other documents concerning the Plan online by visiting [http://financeoffice.gwu.edu/benefits](http://financeoffice.gwu.edu/benefits). You may obtain copies of the documents constituting the Plan and of certain reports by contacting the university’s Benefit Administration Department at (703) 726-8382 (a reasonable charge may be imposed for those 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 (703) 726-8382 if you have questions about this booklet, the Plan or any other Plan materials.
ELIGIBILITY TO PARTICIPATE

Employees Eligible for Participation

An employee of the university who is a regular full-time or part-time Faculty Member or Staff Member and who works at least 14 hours per week is eligible to participate in this Plan.

Individuals Not Eligible for Participation

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

- individuals working less than 14 hours per week;
- faculty members who are part-time and paid on a per-course basis;
- individuals classified by the university as “leased employees;”
- individuals covered by a collective bargaining agreement, unless that collective bargaining agreement provides for the eligibility of such employee to participate in this Plan;
- 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 and of such individual’s employment status under applicable law;
- 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; and
- nonresident aliens with no U.S. source income.

Participation During a Leave of Absence

If you begin a leave of absence approved by the university, your participation in the Plan may continue provided you continue your contributions to the Plan. If your leave of absence is a paid leave, regular payroll deductions will continue. If your leave of absence is an unpaid leave, you may pay on the same schedule as if you were not on leave. If you fail to make payments, your coverage will stop until you return to work, unless you make other arrangements with the university.

Under the Dependent Care FSA, you are only eligible to continue this benefit during a leave of absence if your leave is 30 days or less. If your leave exceeds 30 days, your Dependent Care FSA will end on the last day of the month in which your leave began but you may still submit dependent care expenses incurred through the last day of the month in which the leave began. Upon your return from a leave of absence, you may elect to reinstate your prior Dependent Care FSA election or make a new election within 30 calendar days of the date you return from leave of absence. Please note: Your Dependent Care FSA will not be automatically reinstated. You must make an active election upon return from your leave of absence.
If you go on a leave of absence under the Family Medical and Leave Act of 1993 (“FMLA”), you may be permitted to revoke and later reinstate your elections or make new elections under the Plan to ensure the Plan’s compliance with the FMLA.

If you go on an unpaid leave of absence because of qualified military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”). You are required to pay to continue your coverage. The extension of Health Care FSA coverage can last up to 24 months.

Please contact the university’s Benefit Administration Department at (703) 726-8382 for information regarding payment of premiums while on an 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. You may enroll online at http://benedetails.gwu.edu. Required supporting documents must be submitted to the university’s Benefits Administration Department 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 change in status as described below.

Re-Enrollment

If your employment terminates and you are rehired within 30 calendar days, your elections in effect at your termination are automatically reinstated with your first paycheck, but your coverage is only prospective. If you commence an approved unpaid leave of absence and return within 30 calendar days, your elections in effect at the beginning of your leave of absence are automatically reinstated. However, your elections could be modified if a change in status has occurred as explained below or if a new Plan Year has begun.

If your employment terminates and you are rehired later than 30 calendar days after your previous termination date, you are treated as a newly eligible participant and are subject to the initial enrollment provisions described above. If you commence an approved unpaid leave of absence and return later than 30 calendar days after your leave of absence began, you are treated as a newly eligible participant and are subject to the initial enrollment provisions described above.

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.

Changes to Enrollment Election

Generally, you may not make changes to your health, vision and dental insurance premiums, 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 “change in status.” Your election change must be consistent with the change in status, and you must go online to http://benedetails.gwu.edu within 30 calendar days of the change. The chart below lists events considered to cause a change in status.
## Permitted Change in Status Examples

<table>
<thead>
<tr>
<th>Health, Vision and Dental Premiums and Health Care FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Marriage, death of spouse, divorce, legal separation, annulment.</td>
<td>- Marriage, death of spouse, divorce, legal separation, annulment.</td>
</tr>
<tr>
<td>- Birth, adoption or death of dependent (“dependent” is defined under the “Covering Eligible Health Care Expenses Using Your Health Care FSA” section on page 8).</td>
<td>- 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 13).</td>
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<tr>
<td>- Change in your or your spouse’s employment status (that causes a loss or gain of benefits).</td>
<td>- Change in your or your spouse’s employment status (that causes a loss or gain of benefits).</td>
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<tr>
<td>- 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.</td>
<td>- 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.</td>
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<tr>
<td>- Entitlement to Medicare or Medicaid.</td>
<td>- Significant cost change (increase or decrease) imposed by a dependent care provider who is not your relative.</td>
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<tr>
<td>- Changes in coverage of your spouse, former spouse or dependent under another employer’s plan.</td>
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</tr>
</tbody>
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If you wish to change your elections due to a change in status, you must notify the Plan Administrator within 30 calendar days of the change in status event by going online to http://benedetails.gwu.edu. Your election is changed effective as of the first day of the month following (or coinciding with) your election change as long as you have completed your online enrollment and submitted your supporting documents within 30 calendar days of the event date; however, in the case of the birth, adoption or placement for adoption of a new dependent, your change in coverage is retroactive to the date of such event.

### 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.** The summary plan description booklets for health, vision and dental coverage discuss 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 20 for additional details. Note that COBRA does not apply to the Dependent Care FSA.
BEFORE-TAX PREMIUM PAYMENTS

Eligible employees who enroll in the Plan and enroll in coverage under The George Washington University Health Insurance Plan (including vision insurance) and/or The George Washington University Dental Insurance Plan will contribute toward the applicable premiums 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. Eligible dependents for Health Care FSA purposes include your opposite sex spouse, 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). 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, if you have a “domestic partner” whom you cannot claim as a dependent under IRS rules, expenses for your domestic 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 6) 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 6 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. For Plan Years beginning before January 1, 2013, you may deposit a maximum of $5,000, or a minimum of $100, per Plan Year into your Health Care FSA. For Plan Years beginning on and after January 1, 2013, you may deposit a maximum of $2,500, or a minimum of $100, per Plan year into your Health Care FSA. After you choose a contribution amount, your contributions are deducted automatically 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 10). 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 $4,000 contribution and you incur $3,000 in qualifying expenses in February of the Plan Year, the $3,000 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 2012 Plan Year, you may submit requests for reimbursement for qualifying expenses you incur on or before March 15, 2013. 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, 2013).

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 recharacterized 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. For example, beginning January 1, 2011, you may be reimbursed for over-the-counter drugs/medicines only if prescribed 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 remain eligible without a prescription (such as bandages, arm/leg/back braces, crutches/mobility aids and contact lens supplies.) Prior to January 1, 2011, all over the counter medications were eligible expenses.

<table>
<thead>
<tr>
<th>Qualifying Health Care Expense Examples</th>
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<tbody>
<tr>
<td><strong>Medical Care examples:</strong></td>
</tr>
<tr>
<td>• Birthing centers.</td>
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<tr>
<td>• Blood, plasma, oxygen.</td>
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<td>• Hospital, surgical or medical treatment charges exceeding insurance reimbursement maximums.</td>
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<td>• Child health care expenses related to adoption (if incurred after adoption negotiations began).</td>
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<td>• Deductible, copayment and coinsurance expenses not paid under medical plan coverage.</td>
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<td>• Doctor’s office or home visits.</td>
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<td><strong>Rehabilitation examples:</strong></td>
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<tr>
<td>• Physical therapy.</td>
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<td>• Prosthetic devices.</td>
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<td>• Special equipment.</td>
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<td><strong>Hearing Care examples:</strong></td>
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<tr>
<td>• Audiometric exam.</td>
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<tr>
<td>• Hearing aid batteries.</td>
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<tr>
<td>• Hearing aid.</td>
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<tr>
<td>• Hearing exam.</td>
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\[1\] 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.
- Lip-reading training.
- Sign language training.

**Vision Care examples:**
- Prescription glasses.
- Contact lenses.
- Eye exam by optometrist or ophthalmologist.

### 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.
- Meals.
- Nonprescription items that are used for general health (such as vitamins and dietary supplements).
- Over-the-counter medications other than insulin, if prescribed.

- Nonreconstructive 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.
DEPENDING CARE FLEXIBLE SPENDING ACCOUNT
(DEPENDING 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 partner” whom you cannot claim as a dependent under IRS rules, then your domestic partner (and your domestic 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 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 automatically 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 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 14). 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 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.

<table>
<thead>
<tr>
<th>Qualifying Dependent Care Expense Examples</th>
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<tbody>
<tr>
<td>• Pre-school, day camp, care before or after school and adult day care.</td>
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<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• A housekeeper whose duties include watching your children or disabled relatives while you work.</td>
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<td>• 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.</td>
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The following list includes examples of types of expenses not eligible for reimbursement under your Dependent Care FSA:

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<thead>
<tr>
<th>Expenses Not Eligible for Dependent Care FSA Reimbursement</th>
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<tbody>
<tr>
<td>• Unlicensed day care or adult care centers.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• Care provided by your spouse or another</td>
</tr>
<tr>
<td>• Kindergarten that is primarily educational in nature.</td>
</tr>
<tr>
<td>• Overnight camp.</td>
</tr>
<tr>
<td>• Babysitters for times when you are not at work.</td>
</tr>
<tr>
<td>• Nursing homes or institutions if the</td>
</tr>
</tbody>
</table>

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 the university’s Benefit Administration Department for further details.
<table>
<thead>
<tr>
<th>Expenses Not Eligible for Dependent Care FSA Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>person you can claim as a dependent for income tax purposes.</td>
</tr>
</tbody>
</table>

**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 https://www.healthhub.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 noneligible 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.

- 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 1-800-284-4885 to obtain a list of approved vendors.
CLAIM REVIEW AND APPEAL PROCEDURES

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

A request for benefits is a “claim” subject to these procedures. In general, claims must be filed in writing with the Claims Administrator, as defined below. 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 that your inquiry is an attempt to file a claim. 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.

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 16 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 to your 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. Any lawsuit by you against the Claims Administrator must be commenced within 12 months from the date of the Claims Administrator’s decision on appeal.
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 university in writing within 60 calendar days of the qualifying event. 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 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 PayFlex for more information on premium costs at (800) 284-4885.

Website: [https://www.healthhub.com](https://www.healthhub.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 appeals for the Health Care FSA and the Dependent Care FSA to PayFlex.

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) are 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

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Name</strong></td>
<td>The George Washington University Flexible Benefits Plan</td>
</tr>
<tr>
<td><strong>Plan Sponsor</strong></td>
<td>The George Washington University</td>
</tr>
<tr>
<td></td>
<td>45155 Research Place, Suite 160</td>
</tr>
<tr>
<td></td>
<td>Ashburn, VA 20147</td>
</tr>
<tr>
<td></td>
<td>(703) 726-8382</td>
</tr>
<tr>
<td><strong>Plan Administrator</strong></td>
<td>Plan Administration Committee</td>
</tr>
<tr>
<td></td>
<td>The George Washington University</td>
</tr>
<tr>
<td></td>
<td>45155 Research Place, Suite 160</td>
</tr>
<tr>
<td></td>
<td>Ashburn, VA 20147</td>
</tr>
<tr>
<td></td>
<td>(703) 726-8324</td>
</tr>
<tr>
<td><strong>Employer Identification Number</strong></td>
<td>53-0196584</td>
</tr>
<tr>
<td><strong>Plan Number</strong></td>
<td>512</td>
</tr>
<tr>
<td><strong>Plan Year</strong></td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td><strong>Type of Plan</strong></td>
<td>The Plan is a welfare plan providing premium conversion and health and dependent care reimbursement.</td>
</tr>
<tr>
<td><strong>Administration and Funding</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Agent to Receive Legal Process</strong></td>
<td>Office of the Senior Vice President and General Counsel</td>
</tr>
<tr>
<td></td>
<td>The George Washington University</td>
</tr>
<tr>
<td></td>
<td>2100 Pennsylvania Avenue, NW, Suite 250</td>
</tr>
<tr>
<td></td>
<td>Washington, DC 20052</td>
</tr>
<tr>
<td><strong>Plan Contributions</strong></td>
<td>Contributions are paid by Plan participants.</td>
</tr>
</tbody>
</table>
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 Plan, you should contact PayFlex. 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.
SECOND AMENDMENT TO
THE GEORGE WASHINGTON UNIVERSITY
FLEXIBLE BENEFITS PLAN
(Effective May 1, 1990, amended and restated April 1, 2012)

Amendment to The George Washington University Flexible Benefits Plan (the “Plan”) by The George Washington University (the “University”).

WITNESSETH:

WHEREAS, the Plan was adopted effective May 1, 1990 and amended and restated effective April 1, 2012;

WHEREAS, the University desires to comply with the Supreme Court decision in United States v. Windsor, interpreting section 3 of the Defense of Marriage Act (DOMA); and

WHEREAS, the University desires to comply with Internal Revenue Service Notice 2014-1; and

WHEREAS, the University wishes to enable Participants to make mid-year changes to medical plan elections due to a reduction in hours of service or enrollment in a medical plan through an Exchange, as authorized by Internal Revenue Service Notice 2014-55; and

WHEREAS, the University wishes to reflect the adoption of The George Washington University Health and Welfare Benefit Plan; and

WHEREAS, Section 5.1 of the Plan permits the University to amend the Plan at any time.

NOW, THEREFORE, the Plan is amended as follows, effective January 1, 2013, except as set forth below:

1. Effective January 1, 2014, new definitions shall be added to Section 1.1 as follows:
"Health Insurance Marketplace" means an organization set up by a state or the federal government to facilitate the purchase of health insurance in each state in accordance with the Patient Protection and Affordable Care Act of 2010.

"Medical Benefit" means the Medical Benefit under The George Washington University Health and Welfare Benefits Plan or such successor plan as the University shall make available to Eligible Employees.

"Qualified Health Plan" means an insurance plan that is certified by the Health Insurance Marketplace and meets certain minimum standards of coverage required by the Patient Protection and Affordable Care Act of 2010.

2. Effective January 1, 2014, Section 3.5 is amended to include a new Section 3.5(h), and the remaining subsections of Section 3.5 shall be renumbered accordingly, as follows:

(h) Revocation due to Reduction in Hours of Service or Enrollment in a Qualified Health Plan. With respect to the Medical Benefit, the following shall apply:

1. Revocation Due to a Reduction in Hours of Service. A Participant may revoke an election that is on account of, and corresponds with, a change in the Participant’s hours of service if:

i. the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week, and there is a change in that Participant’s status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Medical Benefit; and

ii. the revocation of the election of coverage under the Medical Benefit corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in another plan offered under the Health and Welfare Benefit Plan that provides minimum essential coverage, with the new
compensation received by the Participant and contributed by the Participant on an after-tax basis.

4. Plan Section A-1 in Appendix A is amended to read as follows (with new language reflected in bold italics and deleted language struck through):

A-1 Qualified Benefits. The following Qualified Benefits are available under the terms of the Plan:

(a) Premium payments under The George Washington University Health Insurance and Welfare Benefit Plan for the Medical Benefit, the Dental Benefit, and the Vision Benefit.

(b) Premium payments under the George Washington University Dental Insurance Plan.

(b) Contributions to a Health Care Flexible Spending Account described in Appendix B.

(c) Contributions to a Dependent Care Flexible Spending Account described in Appendix C.

5. Plan Section B-1 in Appendix B is amended to read as follows (with new language reflected in bold italics and deleted language struck through):

B-1 "Dependent" shall mean (a) the Participant's opposite-sex spouse and (b) any individual who is either (i) a Participant's child who is under age 26 and is not eligible for other employer-sponsored coverage through his or her employer or his or her spouse's employer; or (ii) a dependent of the Participant within the meaning of Code Section 152 (without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof). Dependents cannot include a domestic partner, civil union member, or the dependents of either unless they are a dependent under Code Section 152 Code (without regard to Code Sections (b)(1), (b)(2) and (d)(1)(B)).
coverage effective no later than the first day of the second month following the month
that includes the date the original coverage is revoked.

(2) Revocation due to Enrollment in a Qualified Health Plan.
A Participant may revoke an election and enroll in a Qualified Health Plan if:

(i) the Participant is eligible for a special enrollment
right to enroll in a Qualified Health Plan through a Health Insurance Marketplace
pursuant to guidance issued by the U.S. Department of Health and Human Services and
any other applicable guidance, or the Participant seeks to enroll in a Qualified Health
Plan through a Health Insurance Marketplace during the Health Insurance Marketplace’s
annual open enrollment period; and

(ii) the revocation of the election of coverage under the
Medical Benefit corresponds to the intended enrollment of the Participant and any related
individuals who cease coverage due to the revocation in a Qualified Health Plan through
a Health Insurance Marketplace for new coverage that is effective beginning no later than
the day immediately following the last day of the original coverage that is revoked.

3. Plan Section 3.8 is amended to read as follows (with new language reflected in bold italics
and deleted language struck through):

3.8 Special Rule for Certain Covered Individuals. Notwithstanding anything in
this Plan to the contrary, the cost of providing Qualified Benefits to an individual as a
dependent of the Participant (where the covered individual is a same sex spouse,
domestic partner, civil union partner or child who is not a dependent of the Participant
for purposes of Code Section 152, determined without regard to subsection (b)(1), (b)(2)
and (d)(1)(B) thereof and who is otherwise permitted to be covered under the terms of
each Qualified Benefit) shall be treated as being paid by the Participant with after-tax
contributions. Even though such Qualified Benefits are purchased by the Participant
from his Benefit Credit Account, the full cost of such Qualified Benefit for such an
individual shall be treated for withholding and reporting purposes as taxable
6. Plan Section C-1 in Appendix C is amended to read as follows (with new language reflected in bold italics and deleted language struck through):

   C-1  "**Earned Income**" shall mean an individual’s wages, pay, tips and other employee compensation, plus the amount of the individual’s net earnings from self-employment for the taxable year, but shall not include pensions or annuities, amounts to which Code Section 871(a) applies (relating to income of a nonresident alien individual not connected with a United States business) or amounts paid or incurred by the University for dependent care assistance to an employee; provided, however, that in the case of a Participant’s opposite sex spouse who is a student or physically or mentally incapable of self-care, such opposite sex spouse shall be deemed for each month during which such opposite sex spouse is a full-time student at an educational institution, or is incapable of self-care, to be gainfully employed and to have earned income of not less than (a) $250, if there is one Qualifying Individual with respect to the Participant for the taxable year or (b) $500, if there are two or more Qualifying Individuals for the taxable year.

   "**Qualifying Individual**" shall mean (a) the Participant’s child, grandchild, brother or sister who is under age 13, who lives with the Participant for more than one-half of the year and who does not provide more than one-half of his or her own support for the year, (b) a disabled spouse who lives with the Participant for more than one-half of the year, and (c) a disabled relative or household member who is principally dependent on the Participant for support, who lives with the Participant for more than one-half of the year and who does not have gross income in excess of the exemption amount specified in Code Section 151(d). A Qualifying Individual cannot include a domestic partner, civil union **member partner**, or the dependents of either unless they are also a dependent under Code Section 152 (without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) who meets the requirements above.

7. Plan Section C-3 in Appendix C is amended to read as follows (with deleted language struck through):

   C-3  **Coverage.** A Participant may elect benefits of no more than $5,000 per Plan Year. Notwithstanding the foregoing, the Plan Administrator may require the Participant to
state (and the University shall be entitled to rely on such statement) at the time elections are made under the Plan that it is reasonably expected based on circumstances at the time of the election that his or her contribution to provide Dependent Care Expense reimbursement for the Plan Year will not exceed the lowest of:

(a) $5,000 per calendar year (or $2,500 in the case where a separate federal income tax return is filed by a married Participant); or

(b) if the Participant is single or is married and earns less than his or her opposite sex spouse in a calendar year, the compensation paid to the Employee by the University as reflected on his Form W-2 for the year; or

(c) if the Participant is married and the Earned Income of his or her opposite sex spouse is less than the compensation paid to the Employee by the University in a calendar year, the Earned Income of the opposite sex spouse.

The Plan Administrator may require that the Participant and/or his or her opposite sex spouse certify to the Employer the amount of such spouse’s expected Earned Income for the Plan Year in question and may require that the Participant provide documentary evidence of the amount certified in the form of an employment contract, paycheck stub, medical records (if the spouse is incapacitated) or a school enrollment form (if the spouse is a full-time student). A Participant who fails to follow the Election Procedure for any Plan Year shall be deemed to have elected no coverage under this Account. Once a Participant elects to receive benefits under this Appendix C, no amounts contributed to the Dependent Care Flexible Spending Account can be received in the form of any other benefit permitted under the Plan, received as cash, or received in any other fashion in lieu of benefits under the Dependent Care Flexible Spending Account.

IN WITNESS WHEREOF, the undersigned, to the full extent of the authority granted under the Plan by its terms, has caused this Second Amendment to The George Washington University Flexible Benefits Plan to be executed as of this _____ day of ________________, 2014.
Title: ____________________