Plan Document and
Summary Plan Description for the
George Washington Academy Health & Welfare
Benefit Plan

- Your Health Care Benefits
- Your Health Savings Account ("HSA")

EFFECTIVE DATE: 07/01/2013
Introduction

George Washington Academy (the “Employer” or “Company”) is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet provides information about your medical/prescription drug, dental, vision, Health Savings Account Benefit Programs. It serves as the Plan document and the Summary Plan Description (“SPD”) for the George Washington Academy Health & Welfare Benefit Plan (“the Plan”).

Note: A separate SPD has been issued that describes information for the following Benefit Program(s):

Flexible Spending Account.

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended.

The “Benefit Programs” covered by this SPD are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits, the Certificate of Insurance or Certificate of Coverage and other descriptive documents relating to each Benefit Program (collectively, the “insurance certificates”) are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.
# Table of Contents

**Introduction** .................................................................................................................. 2  
**Plan Overview** .................................................................................................................. 7  
- Your Eligibility .................................................................................................................. 7  
- Eligible Dependents ............................................................................................................. 7  
- When Coverage Begins ...................................................................................................... 8  
- Proof of Dependent Eligibility ............................................................................................ 8  
- Your Contribution for Coverage ......................................................................................... 8  
- Enrolling for Coverage ....................................................................................................... 9  
  - New Hire Enrollment ........................................................................................................ 9  
  - Late Entrant ....................................................................................................................... 9  
- Special Restrictions for Pre-existing Conditions ................................................................. 9  
- Annual Open Enrollment Period ........................................................................................... 10  
- Effect of Section 125 Tax Regulations on this Plan .............................................................. 10  
- Qualifying Change in Status ............................................................................................... 10  
- Special Enrollment Rights .................................................................................................... 11  
- When Coverage Ends .......................................................................................................... 12  
- Cancellation of Coverage .................................................................................................... 12  
- Rescission of Coverage ...................................................................................................... 12  
- Coverage While Not at Work .............................................................................................. 12  
- If You Take a Leave of Absence (FMLA) ............................................................................ 13  
- If You Take a Military Leave of Absence ........................................................................... 13  

**Your Health Care Coverage** .............................................................................................. 14  
- Participation ....................................................................................................................... 14  
- Benefits Provided ............................................................................................................... 14  
- Source of Payments .......................................................................................................... 15  
- Limitations and Exclusions ............................................................................................... 15  
- Continuation of Health Care Coverage through COBRA .................................................. 15  
- For More Information ....................................................................................................... 15  

**Your Health Savings Account (“HSA”)** ............................................................................ 16  
- How the HSA Works ........................................................................................................... 16  
- Catch-Up Contributions ...................................................................................................... 17  
- Government Regulations and Your HSA .......................................................................... 17  
- How to File a Claim ............................................................................................................ 17  
- When Participation Ends - Health Savings Account ......................................................... 17  
- If You Die ........................................................................................................................... 18  
- Additional Information ...................................................................................................... 18  

**Administrative Information** ............................................................................................. 19  
- Plan Sponsor and Administrator ....................................................................................... 19  
- Plan Year ............................................................................................................................ 20  
- Type of Plan ....................................................................................................................... 20  
- Identification Numbers ...................................................................................................... 20  
- Plan Funding and Type of Administration ......................................................................... 20  
- Insurers/Claims Administrators .......................................................................................... 21
Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee normally scheduled to work 30 hours per week.

The following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, part-time employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Employer payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;

"Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- a step child as long as you are married to the child's natural parent;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).
In addition, an eligible dependent who lives outside the U.S. may be restricted from coverage unless the dependent has established his or her primary residence with you. If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, the enrollment will be considered a late enrollment.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other’s coverage, but only one of you may cover your dependent children. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

When Coverage Begins
To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins the first of the month following 30 days of employment. Coverage for your eligible dependents begins on the same day as your initial eligibility provided you enroll your dependents within 31 days of eligibility. Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements to be covered under the Plan.

Proof of Dependent Eligibility
The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent’s eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

Your Contribution for Coverage
Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the Employer in your enrollment materials and on your Election Form which are incorporated herein by reference. You may also request a copy of any required contribution amounts from the Plan Administrator.
For most benefits, you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars. You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

Enrolling for Coverage

New Hire Enrollment
As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

Late Entrant
An enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period to enroll in coverage.

Special Restrictions for Pre-existing Conditions
For purposes of the Medical Benefit Program, a "pre-existing condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended by or received from a physician during the 6 months before an individual’s enrollment date. No pre-existing condition exclusion will apply to any participant under age 19. A pregnancy will not be considered a pre-existing condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

If you enroll in the Medical Benefit Program when first eligible, any pre-existing condition will not be covered until the 12 months anniversary of your enrollment date. If you are a late entrant, this period may be extended. Refer to the insurance certificate and other materials provided by the Insurer for the coverage in which you enroll for additional information.

The pre-existing condition waiting period may be reduced or eliminated if you show proof that you had “creditable coverage” — but only if you had less than a 63-day break in coverage (i.e., not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements). You must provide a certificate of creditable coverage from your prior health plan. If
you are unable to obtain a certificate of creditable coverage, you may be able to provide proof of
your prior coverage through other documentation approved by the Insurer. Contact the Plan
Administrator to obtain additional information about creditable coverage.

Annual Open Enrollment Period
Each year during a designated open enrollment period, you will be given an opportunity to make
your elections for the upcoming year. Your enrollment materials and Election Form will provide the
options available to you and your share of the premium cost, as well as any default coverage you
will be deemed to have elected if you do not make an election by the specified deadline. The
elections you make will take effect on July 1 and stay in effect through June 30, the Plan Year,
unless you have a qualifying change in status. The Plan Year may differ from the policy year of an
insured benefit, with deductible and out-of-pocket expenses based on the policy year. You should
refer to the insurance certificate and other materials provided by the Insurer to determine if a
different policy year applies.

Effect of Section 125 Tax Regulations on this Plan
It is intended that this Plan meets the requirements of Code Section 125 and the regulations
thereunder and that the qualified benefits which you may elect are eligible for exclusion from
income. The Plan is designed and administered in accordance with those regulations. This
enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Employer
nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by
you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make
changes to your elections. Generally, your elections stay in effect for the Plan Year and you can
make changes only during each annual open enrollment. However, at any time throughout the
year, you can make changes to your coverage within 31 days of the following:
• The date you have a qualifying change in status as described below; or
• The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status
If you experience a change in certain family or employment circumstances that results in you or a
covered dependent gaining or losing eligibility under a health plan, you can change your coverage
to fit your new situation without waiting for the next annual open enrollment period.

As defined by Internal Revenue Code Section 125, or the regulations thereunder, the following
events may be considered a change in status:
• your marriage;
• the birth, adoption, or placement for adoption of a child;
• your death or the death of your spouse or other eligible dependent;
• your divorce, annulment, or legal separation;
• a change in a dependent child’s eligibility;
• a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
• a change in your Employer work location or home address that changes your overall benefit options and/or prices;
• a significant change in coverage or the cost of coverage;
• a reduction or loss of your or a dependent’s coverage under this or another plan; or
• a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with the status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change to the Plan Administrator as soon as possible, but no later than 31 days after the event occurs.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents in this Plan, without being considered a Late Entrant, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll them until the next annual open enrollment period.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children’s Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This “special enrollment right” exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.
When Coverage Ends
Except as otherwise provided in the insurance certificate, your coverage under this Plan ends End of the month of termination. Coverage may be extended under certain circumstances, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage
If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage
Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work
In certain situations, coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you take an unpaid leave of absence, you will need to make payment arrangements prior to the start of your leave. Your payments will be made on an after-tax basis, unless you are on paid leave, in which case your premium payments will continue to be deducted on a pre-tax basis. You should discuss with Human Resources or your supervisor what options are available for paying your share of costs while you are absent from work.
If You Take a Leave of Absence (FMLA)

If you take an approved FMLA leave of absence, your coverage will continue for the duration of your leave, as long as you continue to pay your share of the cost as required under the Employer's FMLA Policy. Coverage for other benefits can be found in the insurance certificates for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, coverage may continue for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) starting on the date your military service begins.

Coverage for other benefits can be found in the insurance certificates furnished by the Insurer for the respective Benefit Programs in which you have enrolled and will be governed by the provisions of USERRA.
Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Dental
- Vision

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer’s benefits booklets. You will automatically receive identification cards for you and your enrolled dependents when your enrollment is processed.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost. You have the flexibility to choose providers inside or outside the network each time you need services.

You may choose from several types of medical plans or programs of benefits under this Plan, including:

- a PPO (Preferred Provider Organization)
- an HDHP w/ HSA (Health Savings Account).

Generally, when you use network providers, the Plan pays the negotiated amount of covered expenses (after any deductible) to your provider and there are no claim forms to complete. For example, under a PPO or CDHP network, you may receive care from any provider you choose with no referral required. However, if you choose a provider who participates in the Plan's network, your costs will be lower since network providers have agreed to accept a negotiated rate as payment in full. If you receive care outside of the Plan's network, benefits are based on reasonable and customary charges and, in most cases, you must pay your portion of the cost, plus any amount billed over the reasonable and customary limits. You may also be required to file claim forms for reimbursement. Your Certificate of Coverage and other documents provide additional information on how benefits are paid when you access in-network providers and out-of-network providers.

When you enroll in a Plan that uses a network of physicians, you are not required to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist. For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.
Source of Payments
Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown on your Election Form. Your premiums will be deducted from your pay on a pre-tax basis.

Limitations and Exclusions
The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA
If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan or your (or your dependent's) exceeding a maximum amount under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). Health care coverage may continue at your own expense for a specific length of time. See the section entitled “Your HIPAA/COBRA Rights” for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information
If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.
Your Health Savings Account (“HSA”)

Your medical coverage enables you to establish an HSA. In order to participate in the HSA, you will need to open an account at an approved financial institution that will be used to pay for current and future health care expenses. This account can be funded by both Employer and your own contributions.

How the HSA Works

An HSA works in conjunction with a high-deductible health plan (“HDHP”). Basically, it consists of 2 parts:

• the HDHP, as defined by the IRS that covers eligible health care expenses after you meet your deductible.

• a savings account to which both you and the Employer can contribute. As your savings accumulate (on a tax-free basis), you have the opportunity to direct how your money is invested.

The HSA is not a part of the HDHP and is not sponsored by your Employer. The information in this section is provided only as an overview of the HSA benefit.

Your employer may contribute an annual amount (as shown in your enrollment materials) to your HSA. This amount may be a flat dollar amount payable to all participants or it may be based on the coverage you select (i.e., individual or family). The amount your Employer deposits into your account is not taxable for Federal tax purposes; however, it may be taxable for state purposes, depending on your state of residence.

After you open your account, you can make contributions to your HSA by personal check. These contributions may be deducted on your Federal income tax return, using IRS Form 1040 and Form 8889. You can contribute up to the maximum annual contribution limit permitted by law, but certain rules apply to future years if your initial year of participation is a partial year. The annual maximum amount (a combination of your Employer’s contribution and yours) is set each year by the IRS. For example, the maximum contribution limit for an individual with family HDHP coverage increased by $200 to $6,450 in 2013. The IRS also determines the minimum annual deductible amount for an HDHP, as well as the limits for out-of-pocket maximum amounts. You may wish to discuss your individual tax situation with your tax advisor or obtain IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans, available at the IRS website below.

Funds must be deposited into your HSA before eligible expenses can be reimbursed. You can use funds in your account to pay for current and future qualified health care expenses. These include medical and prescription drug expenses, as well as deductible and coinsurance amounts, for yourself and your eligible dependents. A complete list of qualified medical expenses may be found in IRS Publication 502, available at www.medicare.gov or www.irs.gov.

In addition, you can use these funds for other qualified expenses, such as dental, vision, and alternative medicine expenses, and for certain non-health care expenses. However, if you use the money in your account for non-health care expenses, the amount is subject to ordinary income tax, plus a tax penalty if you are under age 65. The tax penalty generally does not apply if the distribution occurs after you reach age 65, become disabled, or die; however, ordinary income tax may still apply.
Catch-Up Contributions
If you are age 55 or older, you are permitted to make a “catch-up” contribution to your HSA. The amount you are eligible to contribute is determined annually by the IRS.

Government Regulations and Your HSA
Participation in an HSA is subject to the following IRS regulations:

- Your medical and prescription drug expenses are combined toward meeting your deductible - there is not a separate deductible for prescription drug expenses. This means that you have to pay the full cost for prescriptions, as well as medical expenses until you have paid the applicable deductible amount (individual or family). Then the plan starts to pay.
- You cannot be enrolled in other medical coverage (including a plan through your spouse’s employer) that is not considered a “high-deductible health plan,” even as a dependent. However, you can participate in a limited-purpose HRA or health care FSA that reimburses or pays dental and vision expenses, or preventive care expenses that can be paid without satisfying the deductible.
- You cannot be enrolled under your spouse’s plan, including a low-deductible coverage (medical or prescription drug).
- You cannot be enrolled in Medicare coverage. Additionally, if you itemize deductions on your Federal income tax return, you cannot deduct HSA contributions as Section 213 medical expenses.

For additional information about how the HSA works with other types of coverage to which you may be eligible, refer to IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans.

How to File a Claim
You will receive information about how to file a claim for reimbursement when you open your account. Depending on where your account is, you may be issued a debit card or checkbook to pay for eligible expenses. It is important for you to keep receipts in order to document expenses for any tax year that may come under review.

When Participation Ends - Health Savings Account
If your medical coverage under the Plan terminates for any reason other than death, the funds in your HSA account are yours. Your HSA is portable which means you can continue to use the funds you have accumulated. You can also make tax-free contributions to your HSA if you participate in another high-deductible health plan. You may continue to use your HSA to pay for eligible medical, prescription drug, dental, and/or vision expenses, or you may elect to leave the money in your account grow on a tax-free basis to use for future health care expenses. However, once you enroll in Medicare or are no longer covered by a high-deductible health plan, as defined by the IRS, you are not permitted to make contributions to your savings account.

You may use your HSA funds to pay Medicare Part A and/or B premiums. Payment of Medicare premiums is a qualified expense and a tax-free distribution. If you are 65 or older, HSA distributions used for non-qualified expenses will be subject to ordinary income tax but exempt from the additional penalty tax.
If You Die
Your HSA is an inheritable account. What happens to your HSA when you die depends upon whom you named as your beneficiary:

- If your spouse is your designated beneficiary, the account will be treated as your spouse’s HSA after your death. The account will continue to be tax-free for qualified medical distributions. If your spouse is covered under another high-deductible health plan, he or she can make his or her own contributions to the HSA, up to the maximum limits.

- If you designate someone other than your spouse as the beneficiary:
  - The account stops being an HSA on the date of your death;
  - The fair market value of the HSA becomes taxable to the beneficiary in the year in which you die (without penalties); and
  - The amount taxable to a beneficiary (other than your estate) is reduced by any qualified medical expenses you incurred prior to your death that are paid from the HSA by the beneficiary within one year after the date of death.

- If your estate is the beneficiary, the value of your account is included on your final income tax return.

You will need to designate a beneficiary when you open your HSA.

Additional Information
For additional information about your HSA, contact the financial institution where your account is established. Since the rules governing HSAs are complex, you may also wish to obtain a copy of IRS Publication 969 - Health Savings Accounts and Other Tax-Favored Health Plans.
Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is a Federal law. This Summary Plan Description is issued in accordance with ERISA and may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

George Washington Academy is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Plan Administrator
George Washington Academy
2277 South 3000 East
Saint George, UT 84790
435-673-2232

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

**Plan Year**
The Plan Year is July 1 through June 30.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies to certain annualized benefits.

**Type of Plan**
This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

**Identification Numbers**
The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 20-4287601        PLAN NUMBER: 502

**Plan Funding and Type of Administration**
Funding and administration of the Plan is as follows.

<table>
<thead>
<tr>
<th>Type of Administration</th>
<th>The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.</td>
</tr>
</tbody>
</table>

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from...
its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

**Insurers/Claims Administrators**

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan Documents always control, even if their terms conflict with information given to you by an Insurer or other service provider.

**Medical/Prescription Drug Benefits**

Regence Blue Cross Blue Shield of Utah  
2890 E Cottonwood Parkway  
Salt Lake City, UT 84130  
801-333-2100  
www.ut.regence.com

**Dental Benefits**

EMI Health Voluntary Dental Coverage  
852 East Arrowhead Lane  
Salt Lake City, UT 84107  
800-662-5850  
www.educatorsmutual.com

**Vision Benefits**

Fidelity Security Life Insurance/ EyeMed Voluntary Vision Coverage  
PO Box 632530  
Cincinnati, OH 45263-2530  
877-205-7682  
http://portal.eyemedvisioncare.com/wps/portal/em/eyemed/members

**Agent for Service of Legal Process**

For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:  
George Washington Academy  
2277 South 3000 East
No Obligation to Continue Employment
The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer’s right to terminate your employment, with or without cause.

Non-Alienation of Benefits
With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

Severability
If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits to Others
The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses
All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the Employer elects or is required by law to pay such expenses.

Fraud
No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

Indemnity
To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative (“Plan Administration Employee”) of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.
Compliance with State and Federal Mandates

Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), the Women’s Health and Cancer Rights Act of 1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle’s Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions

For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants’ portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.
Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer’s decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program's provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

22
Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer’s plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits. The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers’ plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

Health Care Coverage Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first (“primary”) is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer’s plan to pay first and Medicare pays second (“secondary”). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer’s coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- **End-stage renal disease**—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.

- **Mandated coverage under another group plan**—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.
Your Rights under ERISA

As a participant in the 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 will be entitled to the following.

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 (if applicable).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

- Continue health care 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.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with 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, or when your COBRA continuation coverage ceases, if you request the certificate 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 pre-existing 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 (if applicable), 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 previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Description and Summary
of Material Modification) and do not receive it 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, after you exhaust your appeals, 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. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan’s decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.
Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights as they pertain to your health insurance benefits. You will receive a separate “Notice of Privacy Provisions” from the Insurer which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Insurer involved with the PHI in question. The Insurer will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Employer or Plan Sponsor with respect to such information. The Employer or Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan’s use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA
Plan’s policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan Sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

**Certificate of Creditable Coverage**

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate never will cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all covered persons in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another copy of the standard certificate and/or the alternative certificate, contact the Insurer within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Insurer may provide this information by phone.
Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the “qualifying event.” These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child’s birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:
• he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
• he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
• he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation
Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:
• death;
• divorce or legal separation;
• eligibility for Medicare coverage; or
• dependent child’s loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications
If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child’s loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.
NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide support for the child, provided you enroll the child within thirty (30) days of the child's birth/adoption/placement.

Cost of COBRA Coverage
You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments
Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA
If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.
When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan’s pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan’s requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.
- The individual becomes entitled to Medicare.
- The Employer terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Additional COBRA Election Period. The Trade Act of 2002 provides an additional COBRA election period for certain eligible Trade Adjustment Assistance (“TAA”) recipients. If you did not elect continuation coverage under the regular COBRA election period, described above, you may elect continuation coverage within the 60-day period that starts on the first day of the month when you are determined to have met the definition of an eligible TAA recipient. However, such election may not be made later than six (6) months after the date you lost coverage as a result of your separation from employment that resulted in you becoming an eligible TAA recipient.
Definitions

COBRA
The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent
The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Your “child” includes:

- Your biological child;
- Your legally adopted child (including any child under age 18 placed in the home during a probationary periods in anticipation of the adoption where there is a legal obligation for support);
- A child for whom you are the court-appointed legal guardian; or
- An eligible child for whom you are required to provide coverage under the terms of a QMCSO or NMSN, as defined below.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, refer to your insurance certificate.

Employee
A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form
The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

ERISA
The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act
The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant’s home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant’s own serious health condition; or
• any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have questions regarding your eligibility for FMLA coverage or your state’s family medical leave provisions, if applicable, contact your Employer.

GINA

HIPAA

HITECH
The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer
Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee
Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare
The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA
The Newborns' and Mother’s Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant
An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.
PPACA
The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)
Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA
The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA
The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.
Adoption of the Plan

The George Washington Academy Health & Welfare Benefit Plan, as stated herein, is hereby adopted as of 07/01/2013. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this __________ day of ________________________________, 201 .

BY: ________________________________

TITLE: ________________________________
## APPENDIX A

**BENEFIT PROGRAMS OFFERED: MEDICAL/PRESCRIPTION DRUG, DENTAL AND VISION.**

<table>
<thead>
<tr>
<th>Benefit Program/Effective Date of Coverage</th>
<th>Name of Insurer/Claims Administrator</th>
<th>Policy or Contract Number(s)</th>
<th>Benefits Provided</th>
<th>Eligibility</th>
<th>Claims Procedure &amp; Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP MEDICAL INSURANCE</strong></td>
<td>REGENECE BLUE CROSS BLUE SHIELD OF UTAH</td>
<td>60006480</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
</tr>
<tr>
<td><strong>PPO</strong></td>
<td>INSURER/CLAIMS ADMINISTRATOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>07/01/2013</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GROUP MEDICAL INSURANCE</strong></td>
<td>REGENECE BLUE CROSS BLUE SHIELD OF UTAH</td>
<td>60006480</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
</tr>
<tr>
<td><strong>HDHP w/ HSA</strong></td>
<td>INSURER/CLAIMS ADMINISTRATOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>07/01/2013</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GROUP DENTAL INSURANCE</strong></td>
<td>EMI HEALTH VOLUNTARY DENTAL COVERAGE</td>
<td>2972</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
</tr>
<tr>
<td><strong>07/01/2013</strong></td>
<td>INSURER/CLAIMS ADMINISTRATOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GROUP VISION BENEFITS</strong></td>
<td>FIDELITY SECURITY LIFE INSURANCE/ EYEMED VOLUNTARY VISION COVERAGE</td>
<td>9852112</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
<td>See Plan/SPD and Certificates of Insurance and other benefit materials provided by Insurer.</td>
</tr>
<tr>
<td><strong>07/01/2013</strong></td>
<td>INSURER/CLAIMS ADMINISTRATOR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear <WHO>,

To provide options for individuals who lose health coverage from an employer-sponsored insurance plan, the Federal Government enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), commonly known as "COBRA." The following will explain your rights under the law and what should be done if you (or a covered dependent) experience a COBRA "qualifying event." A qualifying event is an event that occurs whereby an employee or covered dependent would no longer be eligible to continue under a group health plan. **We request that you and your covered dependents take the time to read this important notification.**

**COBRA LAW** - With a few exceptions, employers with twenty or more employees that provide health benefits are required to offer employees (and/or their covered dependents) the right to a temporary extension of group insurance (called "continuation coverage") upon experiencing a qualifying event. An individual experiencing a qualifying event is referred to as a "qualified beneficiary" and receives many of the rights granted to similarly-situated active employees as it relates to group insurance plans.

Continuation coverage is different from converting to individual coverage after termination of employment. The major advantages of COBRA are that participants will receive the same group plan benefits as a similarly-situated active employee and will be charged the company's group rate (plus a maximum of two percent as an administrative fee). These COBRA rates may (or may not) be less than the premiums charged under a conversion policy so it is recommended that you contact the insurer directly to receive a quote. With many conversion policies, benefits are reduced and premiums are based upon the age and sex of the converting members. Another difference is that COBRA allows for covered dependents to independently continue their health coverage and retain COBRA rights throughout their continuation time frame.

**EMPLOYER AND QUALIFIED BENEFICIARY'S RESPONSIBILITIES** - When you or your covered dependents experience a qualifying event, you will be sent a notification explaining your rights to elect COBRA continuation coverage. The Plan Administrator shall provide this notification within forty-four days from the date of the qualifying event (or as soon as administratively possible). You or your dependents have the responsibility to notify our office of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Keep in mind: qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the plan would have occurred.
If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you are requested to contact the Plan Administrator immediately. Even if you elect not to continue coverage, it is vital you have the information necessary to make an informed decision.

<COMPANY> will know when certain qualifying events (i.e. reduced work hours, employment termination, death of an employee or the employee's entitlement to Medicare) occur. You and your covered dependents will be responsible for notifying our office of a divorce, legal separation or when a dependent loses his/her "dependent status." You or your dependents have sixty days to notify the Plan Administrator of these qualifying events. If the Plan Administrator is not notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension described below, you must also notify us within sixty days of a determination by Social Security that you or a dependent are "disabled."
COBRA QUALIFYING EVENTS - Listed below are qualifying events for which you and/or your covered dependents are able to continue coverage under COBRA. As shown, the maximum continuation coverage time frame depends upon the qualifying event experienced. To be considered a qualified beneficiary, you or your dependent must have been enrolled on the group plan on the day prior to the qualifying event. One exception to this rule is when a child is born to (or placed for adoption with) an employee during the COBRA continuation period. These children will receive all the rights of a qualified beneficiary throughout the COBRA continuation period.

Qualifying Events That Yield a Maximum of Eighteen Months' Coverage (Experienced by the Employee)

1. Termination of employment (for reason other than "gross misconduct");
2. Reduction of employee's work hours.

Qualifying Events That Yield a Maximum of Thirty-six Months' Coverage (Experienced by a Covered Dependent)

1. Death of the employee;
2. Divorce or legal separation;
3. Employee is entitled to Medicare but dependents are not;
4. Dependent child who no longer meets the plan's definition of a "dependent."

Special Medicare Extending Rule - If an active employee becomes entitled to Medicare and later experiences a termination of employment or reduction in work hours, covered dependents may be eligible for thirty-six months of continuation coverage from the date of the Medicare Entitlement. In this situation, dependents shall be eligible for a minimum of eighteen months of COBRA continuation coverage.

EXTENDING COBRA COVERAGE - After electing to continue coverage under COBRA, there are certain situations that may allow qualified beneficiaries to increase the time frame of continuation coverage. If the initial qualifying was termination of employment or a reduction in work hours, qualifying individuals may be eligible to increase their time frame under COBRA. In each of the two situations described below, eligible individuals must notify the Plan Administrator (in writing) as explained.

Disability Extension - If the qualifying event is an employee's termination or reduction in work hours and you or a covered dependent are determined to be "disabled" by Social Security (under Title 11 or Title XVI) either before that qualifying event or within sixty days of such event, you and your covered dependents are eligible for an additional eleven months of coverage (yielding a total of twenty-nine months). For this extension to apply, evidence of disability under the Social Security Act must be provided to the Plan Administrator within the initial eighteen month continuation coverage time frame and within sixty days from the date of Social Security's determination.

Multiple Qualifying Events - If you experience a qualifying event that entitles you and your covered dependents to less than thirty-six months of continuation coverage (including the disability extension described above) and during your period of continuation coverage your covered dependents experience a second (or "multiple") qualifying event, the period of continuation coverage for your covered dependents may be extended under COBRA from eighteen months (or twenty-nine months if disabled) to thirty-six months. The maximum continuation period is thirty-six months regardless of how many qualifying events your covered dependents experience. It is the responsibility of you or your covered dependents to notify the Plan Administrator within sixty days of the multiple qualifying event. Employees who experience a reduction in work hours followed by termination of employment shall only be eligible for eighteen months of continuation coverage under COBRA. To be considered a multiple qualifying event, such event must have caused the qualified beneficiary to lose coverage had the first qualifying event not occurred.

FAMILY AND MEDICAL LEAVE ACT - Under the Family and Medical Leave Act of 1993 (FMLA), eligible employees have the right to take up to twelve weeks of unpaid leave to care for themselves or a relative. If you elect to take this leave and later notify the company that you will not be returning, you have the ability to continue your coverage for eighteen months from the date benefits are terminated on account of your failure to return to work. (FMLA does not apply to all organizations and can differ between states. Please contact a company representative for further information on FMLA.)
COBRA TERMINATION - Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at anytime by notifying our office in advance. In addition, COBRA states that continuation coverage will
end for one or more of the following reasons:

1. The company terminates all of its health plans for similarly situated active employees;
2. COBRA premiums are not paid in a timely manner;
3. You and/or your covered dependents become covered under another group plan after electing continuation coverage and that plan does not exclude a pre-existing medical condition affecting you or your dependents;
4. You become entitled to Medicare (meaning enrolled in Parts A and/or B) after you have elected continuation coverage under COBRA;
5. You or a covered dependent are enrolled in a plan that requires you to live in the plan's "service area" or visit contracted providers and you move out of that service area. However, if another plan is available to similarly situated active employees who move from the service area, coverage under that plan will be offered to you;
6. You file fraudulent claims or engage in other activities for which a similarly situated active employee would be terminated "for cause;" or
7. A "disabled" participant is determined by Social Security to be no longer disabled during the eleven month extension. In that case, the entire family unit will be terminated from COBRA.

**PREMIUM COSTS** - The cost of continuation coverage will be determined at the time of the qualifying event. Your cost will be the amount the insurance company charges <COMPANY> (or if the plan is self insured, the cost of coverage as determined by the company) for similarly situated active employees under the plan plus a <ADMIN FEE>% administration fee. An employee who is deemed to be disabled and who elects the disability extension may be charged a 50% administration fee during the eleven month extension. (If the disabled employee does not elect the disability extension or terminates coverage before the extension would ordinarily end, his/her covered dependent's administration fee will be reduced to <ADMIN FEE>%.) If the firm's premium increases or decreases, the COBRA participant's premiums will be adjusted accordingly. Premium rates for the plan are set for twelve month periods based upon the Plan Year.

If you elect to continue coverage under COBRA, you will be granted an initial forty-five day grace period to make your payment. Your first payment must include the premiums for coverage retroactively to the date you or your covered dependents would have lost coverage if you hadn't elected to continue coverage. Subsequent premium payments will have a thirty day grace period. If premiums are not received within the allotted grace period, COBRA coverage will be terminated back to the date for which premiums were applied. The company asks for full payment by the first of the month but will accept multiple payments (equaling the total monthly premium due) throughout the month of coverage.

**COVERAGE UNDER COBRA** - Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Since COBRA is a continuation of benefits, your benefits will remain the same as prior to the qualifying event. If the company elects to change plans and/or benefits, you will be eligible to enroll in the changed plan and will therefore receive the same benefits as a similarly situated active employee. If your plan has deductibles and coinsurance maximums, these amounts will be based upon expenses incurred prior to the qualifying event by only those family members electing to continue under the plan.

COBRA participants who move from the plan's service area may lose coverage under the group health plan (as would a similarly situated active employee). If the company offers a plan that would provide coverage in the new area, the COBRA participant will be offered the right to enroll in that plan.

**OPEN ENROLLMENT** - COBRA participants are offered the same rights as similarly situated active employees during open enrollment. They may change plans and add/delete eligible dependents. Although part of the family unit, dependents (other than newborn children and adopted children of the employee) added during open enrollment will not have the same COBRA rights as the initial qualified beneficiaries.
The company's open enrollment may vary from year to year so feel free to contact the Plan Administrator for further information on open enrollment.

**CONVERSION POLICIES** - A conversion policy allows individuals covered under a group plan to convert their coverage to an individual policy without a lapse in coverage or a pre-existing condition limitation upon termination from the group plan. Not all group plans offer a conversion right. If you are enrolled in a plan that allows conversion, you will receive a notification explaining conversion privileges in the last 180 days of your COBRA term.
**TRADE ACT OF 2002** – On August 6, 2002, the Trade Act of 2002 was signed into law expanding the benefits available to workers displaced by import competition or shifts of production to other countries. The Trade Act of 1974 initially offered benefits (known as “trade adjustment assistance”) which expired September 30, 2001. The Trade Act of 2002 extended this period to September 30, 2007 and offers qualified workers a tax credit of up to 65% of COBRA health insurance premiums for both them and their family.

To be eligible for the tax credit, you must be currently receiving trade adjustment assistance or considered an “eligible Pension Benefit Guaranty Corporation (PBGC) pension recipient,” paying premiums for qualified health insurance, not receiving other coverage and not in prison. The law also creates a second “election period” for individuals not electing COBRA coverage upon their loss of employment if they are within the six months immediately after their group health plan coverage ended. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)** - The scope of HIPAA is to eliminate barriers for individuals (mainly people with pre-existing medical conditions that would have difficulty obtaining immediate coverage) who lose coverage and want to find a replacement plan. The law limits a plan's "pre-existing condition limitation time frame" to twelve months for newly enrolling individuals and provides credit for prior medical coverage, including COBRA continuation coverage. When you terminate from a group medical plan, you will receive a Certificate of Coverage that illustrates your prior coverage. This certificate should be shown to a new employer to receive one month credit for every month of prior coverage. If there is a break in coverage greater than sixty-three days, the new employer does not have to provide any prior coverage credit. (Individuals receiving trade adjustment assistance and who enroll in COBRA during the "second election period" shall receive creditable coverage even with a break in coverage larger than sixty-three days.)

In addition, if you elect COBRA and keep your coverage for the maximum continuation period available to you, you may be eligible for coverage under an individual plan (through an insurer of your choice) on a guaranteed issue basis without any pre-existing condition limitations.

**PLAN ADMINISTRATOR** - The Plan Administrator is your contact as it relates to COBRA and your continuation coverage. If you have any questions regarding this notification or your continuation coverage, you may review your Plan's Summary Plan Document or contact the Plan Administrator. It is your responsibility to notify the Plan Administrator of any qualifying events and when you have a change of address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**FURTHER INFORMATION AVAILABLE** - For further information concerning your Plan or your COBRA continuation coverage rights, you may contact the insurance carrier(s) identified below. For information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebisa](http://www.dol.gov/ebisa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)
Notice of privacy practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is effective as of April 14, 2003, and was last revised on August 1, 2013.

This notice applies to members covered under Group Health Cooperative and Group Health Options, Inc. plans, as well as the GHC Employee Benefit Plan. This notice also applies to patients receiving care in Group Health Cooperative owned and operated facilities provided by Group Health Physicians (GHP) doctors and clinicians. In this notice the terms “we,” “us,” “our,” and “Group Health” are used to refer to all of these entities.

In this notice, “personal information” refers to any medical or financial information that can be used to identify you and relates to your physical or mental health or condition, the provision of health care to you, or the payment for that care, including your medical record. Personal information may include your name, Social Security number, address, telephone number, employment, medical history, health records, claims information, or credit card number.

This notice is based on state and federal law, as well as our code of ethics. It explains our responsibilities and privacy practices regarding your personal information. Group Health is required to protect the privacy of your personal information, provide you with this notice, and abide by the terms of this notice.

At Group Health, safeguarding your privacy and the confidentiality of your personal information is a priority. Group Health policies and procedures are designed to protect your personal information in written, verbal, and electronic forms. Access to your information is kept to a minimum for the intended purpose and provided only for legitimate business need. Physical, electronic, and other safeguards help to protect against unauthorized access to your information.

About Group Health

Group Health Cooperative and Group Health Options, Inc. offer health care coverage to members through individual and group plans. Group Health Cooperative also delivers care to patients in medical facilities we own and operate. Depending on your relationship with Group Health, we may collect, use, and share your information in slightly different ways.

When you apply for health coverage, Group Health Cooperative or Group Health Options, Inc. may receive your personal information directly from you or from third parties, which may include agents, brokers/ producers, a trust, or your employer. We may share your personal information with the health plan administrator through which you receive your health benefits, to permit them to manage the business functions of the health plan. For example, we may share health plan enrollment and eligibility information with plan administrators. We may also share information that does not identify specific members with a plan administrator.
If you are enrolled in a self-funded plan through your employer, Group Health Cooperative or Group Health Options, Inc., may act as an “administrative services organization” for your self-funded plan and may receive and share information with the plan administrator, usually your employer, for certain administrative activities. For example, we may share claims information for health care services you have received. The plan administrator must confirm that it will protect your personal information in accordance with the law.

If you are a patient at a Group Health Cooperative owned and operated facility, we keep a record of health care services you receive from us, as well as medical records sent to us from other health care providers. We will not share your information with others unless directed by you or otherwise allowed by law.

How we may use and share your personal information
Group Health uses and shares your personal information to provide treatment, receive and provide payment for health care services, and conduct health care operations. Some examples of how we may use or share your personal information without your authorization are described below. If you do not receive your health care from us, some of the following examples may not apply to you.

Treatment
If you are a patient in a Group Health Cooperative medical facility, we may use or share your personal information to provide you medical care. For example, our physicians, nurses, pharmacists, and lab technicians may share your personal information to provide you health care services. In addition, we may share your personal information with health care providers or suppliers outside of Group Health for consultation, referral, or coordination of your care.

Payment and health care operations
If you are a member, covered by Group Health Cooperative or Group Health Options, Inc., we may receive your personal information from health care providers who treat you, so we can pay them in accordance with your health benefit plan. We may also use and share your personal information to carry out health care operations. Health care operations are business activities that support the delivery and payment of health care. Payment or health care operations purposes could include:

- Determining benefit eligibility and coordinating benefits with other health plans
- Reviewing services for medical necessity
- Paying a claim
- Performing utilization review
- Obtaining premiums
- Subrogating a claim
- Collection activities
- Providing care management
- Educating health or other professionals
- Underwriting health plan benefits
- Administering and reviewing a health plan
- Conducting medical reviews
- Providing customer service
- Determining coverage policies
- Performing business planning
- Arranging for legal and auditing services
- Obtaining accreditations and licenses

Please note that Group Health is not allowed to use or share your genetic information for underwriting purposes, to adjust premiums, or to make enrollment or eligibility determinations based on your predisposition to a genetic condition. Group Health is also prohibited from requesting, requiring, or purchasing genetic information about an individual in connection with health plan enrollment.
Group Health may also contract with individuals or entities known as business associates to work on our behalf, which may require us to use and share your personal information with them. Our business associates must agree in writing to safeguard the confidentiality of your personal information in accordance with federal law and this notice.

Disclosures required by law
Certain state and federal laws may require Group Health to share your personal information. For example, we may share your information with:

- **An authorized public health authority** to protect public health and safety; to prevent or control certain diseases, injuries, or conditions; to report vital events such as births or deaths; or to participate in registries such as the cancer registry.

- **The U.S. Food and Drug Administration (FDA)** to investigate or track problems with prescription drugs and medical devices.

- **Workers’ compensation programs**, which provide benefits to you if you have a work-related injury or illness.

- **Government benefits programs**, like Medicare and Medicaid, in order to review your eligibility and enrollment in these programs.

  - **Government entities** authorized to receive reports regarding child or vulnerable adult abuse or neglect.

- **Health oversight agencies**. As health plans and health care providers, we must agree to oversight reviews by federal and state and other agencies. These agencies may conduct audits, perform inspections and investigations, license health care providers, health plans, and health care facilities, and enforce federal and state regulations.

  - **Law enforcement officials** in limited circumstances. For example, disclosures may be made to report a crime on Group Health property.

  - **Armed forces personnel** for military activities and to authorized federal officials for national security activities.

  - **Funeral directors** to assist with their responsibilities.

  - **County coroners** for the investigation of deaths.

  - **Organ procurement organizations** to the extent allowed by law.

  - **Disaster relief organizations** such as the Red Cross to assist in disaster relief efforts.

  - **Correctional facilities** if you are an inmate. We may share your personal information for your health and the health and safety of others.

Group Health may also use or share your personal information without your authorization in the following circumstances:

- **Family, domestic partner, or friend** involved in your care or the payment of your care or a person you identify when you are present and agree, or when you are not present or incapacitated and in our professional judgment it is in your best interest to share information about your care.

- **Appointment reminders**: If you are a patient, to remind you that you have a health care appointment with us.

- **Health information exchange**: If you are a patient, we may make your health information available electronically through an information exchange network to other health care providers involved in your care. The purpose of this exchange is to deliver safer, better coordinated care to you by sharing your health information with other providers caring for you.

- **Plan description**: If you are a member, to communicate with you about our networks, health plans, and providers.
• **Services related to your healthcare and wellness:** If you are a member or patient, to remind you about preventive health services or to let you know about treatment alternatives, providers, settings of care, or health and wellness products or services that are available for you as a member of Group Health.

• **Facility directory information:** If you are a patient in a Group Health facility, we may share your name, the location where you are receiving care, your general health condition, and your religious affiliation in our facility directory unless you tell us that you wish to be excluded.

• **Fundraising:** If you are a member or patient, we may contact you to raise funds for the Group Health Foundation, a nonprofit charitable organization supporting Group Health Cooperative and the community. We only use limited information about you for fundraising appeals and communications. To direct us not to contact you for this purpose, call Group Health Customer Service toll-free at 1-888-901-4636.

• **Research:** If you are a member or patient, for medical and other research conducted by the Group Health Research Institute or other research teams, provided that certain steps are taken to protect your privacy. Generally, an institutional research review board evaluates each research project to ensure that researchers follow processes that will protect your privacy.

• **Education:** We may use and share your information to teach and educate staff and students. For example, teaching physicians may review health information with medical students.

• **Public health and safety:** We may use and share your personal information to avert a threat to the health and safety of a person or the public.

Group Health may share your personal information in response to a court order and, in certain cases, in response to a subpoena, discovery request, or other lawful process.

**Other uses of your personal information**

Except in the situations described above, we will use and share your personal information only with your written permission or authorization. Group Health is not permitted to sell or rent your personal information and may not use or share your personal information for marketing purposes without your authorization. In some situations, federal and state laws provide special protections for sharing specific kinds of personal information and require authorization from you before we can share that specially protected medical information. For example, information about treatment for alcohol or drug abuse, sexually transmitted disease, and mental health is specially protected. In these situations and for any other purpose, we will contact you for the necessary authorization. If you sign an authorization to disclose your health care information, you may withdraw it at any time by letting us know in writing.

**Your rights**

You have rights regarding personal information that we maintain about you. If you do not receive treatment in a Group Health Cooperative facility, some of these statements may not apply to you. You may get more information about exercising these rights by calling the Privacy Office at 206-448-2422.

• **Request restrictions:** You may request that we limit the way we use or share your personal information. Please make your request to us in writing. Group Health will consider your request but is not required to agree to it.

• **Request restriction to a health plan:** You may request that certain health care services or items that you pay for fully at the time of service not be shared with your health plan. Please let your provider know before, or at the time of service or we may not be able to fulfill your request.
• **Confidential communication:** You may ask that we contact you in a certain way or at a certain location, for example at a different address or phone number. We will usually be able to accommodate your request. Please make your request to us in writing.

• **Inspect and copy:** We keep a record of the health care services we provide you. You may review and request a copy of information in your medical record and certain other records maintained by Group Health. We may ask you to make this request in writing. You may see your record or get more information about it at your Group Health Medical Center. We may charge a reasonable fee for the cost of producing and providing you with a paper or electronic copy. In certain situations we may deny your request and tell you why we are denying it. You have the right to ask for a review of our denial.

• **Amendments:** You may ask us to correct or amend information in your records. Your request for a change to your record must be in writing and must give a reason for your request. We may deny your request, but you may respond by filing a written statement of disagreement and ask that the statement be included with your record.

• **Accounting of disclosures:** You may seek an accounting of certain disclosures by asking us for a list of the times we have shared your personal information. Your request must be in writing.

• **Breaches:** You may receive a notice from Group Health about a breach of unsecured personal information if you are affected. We may also inform you of ways you can protect yourself in the event of a breach.

• **Receive an additional copy of this notice:** You may request a paper copy or ask general questions about this notice by calling Group Health Customer Service at 206-901-4636 or toll-free at 1-888-901-4636. You may also view this notice on our website at ghc.org.

Questions and complaints
If you have questions about this notice or want to file a complaint about our privacy practices, write to Group Health Privacy Officer, Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233 or call 206-448-2422.

For more information on how to file a written complaint, call the Privacy Office at 206-448-2422. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you if you file a complaint about our privacy practices.

Changes to privacy practices
We may change the terms of this notice at any time. If we change any of the privacy practices described in this notice, we will post the revised notice on our website, at ghc.org and in Group Health medical facilities. We may give you additional information about our privacy practices in other notices we provide.