ELIGIBILITY AND ENROLLMENT PROVISIONS

To be eligible for the benefits of this plan, you must be a faculty or staff member with at least a half-time appointment. Staff members with half-time appointments who are in regular positions scheduled to work 1,040 hrs. per year or .50 FTE. Faculty members teaching part-time, who do not bear the full range of expectations associated with full-time faculty, have a half-time appointment when they are contracted to teach four units of course work or to meet an equivalent set of responsibilities during the academic year.

For your dependent children to be eligible for the benefits of this plan, the child must be unmarried, non-self-supporting, and under the age of twenty-five (25).

The child must be your natural or adoptive child; a stepchild for whom you and your partner provide at least fifty percent (50%) of the child’s financial support; or a child for whom you are required to provide health benefits pursuant to a court order.

A child who is unmarried and totally disabled for whom you provide at least fifty percent (50%) of the child’s financial support shall be eligible to remain enrolled beyond the age of twenty-five (25) if you request continued coverage for the child within thirty-one days of the child’s twenty-fifth (25th) birthday and provide documentation of disability.

Foster children are not eligible for coverage.

BENEFITS ALLOWANCE

Each eligible faculty and staff member who is enrolled in a university-sponsored medical plan receives a monthly benefits allowance of $370. Full-time faculty and staff members who elect not to enroll in a university-sponsored medical plan receive a monthly benefits allowance of $150. Regular, part-time faculty and staff members (.50-.74 FTE) who elect not to enroll in a university-sponsored medical plan will receive a monthly benefits allowance of $75.

If you have other group medical coverage, through your partner’s employer, for example, you may decide to take no medical coverage through the university. If so, your allowance can be used to pay the cost of enrollment in the dental plan, if you elect that plan, purchase additional life insurance, and/or be credited to your health care and/or dependent care Personal Expense Account(s). Once in your Personal Expense Account(s), money is available throughout the year to reimburse you for certain types of health and dental care and/or dependent care expenses. For a more complete explanation, see Personal Expense Accounts, on page 8.

If the cost for the benefits you select is greater than the allowance, you will pay the difference on a pretax basis through payroll deduction.

Health Risk Appraisal

As an incentive to complete the online health risk appraisal, benefits-eligible faculty and staff who participate will receive an additional $12 per month in flexible benefits allowance dollars ($6 per month for benefits-eligible part-time faculty and staff). The incentive applies even if you are not enrolling in a university medical plan. Family members may participate in the health risk appraisal program; however, the incentive is available only for faculty and staff members who complete the appraisal. You and your family members will have access to all other features of Health-e Outlook described on page 2 even if you do not complete a health risk appraisal.

All health risk appraisal data will be maintained securely, and the confidentiality of participants’ responses is assured. No information apart from the fact that you participated will be shared with the university. American Health Holding will provide the university with the names of faculty and staff members who complete the health risk appraisal only in order to verify eligibility for the allowance incentives. More information on the appraisal and how to complete it can be found on page 3 of this guide.
Allowance Subsidy

Faculty and staff members whose household income is $60,000 or less and who enroll family members in the university-sponsored medical plan may apply for an allowance subsidy. To determine your household income, review the 2004 federal income tax return(s) filed by all persons related and/or unrelated who share housing with you. Following is a table that identifies the monthly allowance subsidy. You may apply for an allowance subsidy by completing the application included in the forms section of this booklet and submitting it to Human Resources along with your other completed forms. See Table 1 for the monthly allowance subsidy.

What “Pretax” Means

You pay your part of the cost of your flexible benefits on a “pretax” basis. This means the money is deducted from your gross earnings before federal income taxes and Social Security taxes are calculated and deducted.

HEALTH-e OUTLOOK™

A new health awareness program called Health-e Outlook™, an American Health Holding, Inc. Web site, is available to faculty and staff and family members 24 hours a day, 7 days a week.

Health-e Outlook provides participants with information tailored to their health needs and gives access to online health management programs. These self-directed programs are personalized to help individuals manage existing medical conditions and reduce the risks of developing new ones.

Key features and benefits of Health-e Outlook include:

- **URAC Accreditation** — Health-e Outlook has received the Utilization Review Accreditation Committee (URAC) Health Web Site Accreditation Seal. Web sites that receive the URAC seal have been thoroughly evaluated against Web site standards to ensure that they deliver quality health content and services.

- **E-Health Dashboard** — Health-e Outlook enables each individual to establish a personalized homepage or “dashboard,” with health programs, records, statistics, reminders and articles.

- **Online Health Management Programs** — Online, self-directed health management programs are available for diabetes, heart disease, asthma, pregnancy, and fitness and nutrition. These programs enable individuals to track, graph and report important health-related data using the secure Health-e Outlook Web site. The health management programs provide action steps, diet, and exercise plans customized to each individual’s needs.

- **Personal Health Record** — Health-e Outlook can serve as an online, self-directed, secure repository for medical records and health information. Health-e Outlook’s integrated calendar can be directed by participants to e-mail health care appointment reminders.

- **Comprehensive Health Information** — The site provides consumer-friendly, encyclopedic health information that promotes healthier lifestyles.

### Table 1 - Monthly Allowance Subsidy

<table>
<thead>
<tr>
<th>Total Household Income Reported in 2004</th>
<th>Spouse</th>
<th>Spouse &amp; Child</th>
<th>Spouse &amp; Children</th>
<th>Child</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0-10,000</td>
<td>$206</td>
<td>$316</td>
<td>$425</td>
<td>$110</td>
<td>$219</td>
</tr>
<tr>
<td>$10,000-15,000</td>
<td>$188</td>
<td>$289</td>
<td>$390</td>
<td>$101</td>
<td>$202</td>
</tr>
<tr>
<td>$15,001-20,000</td>
<td>$172</td>
<td>$264</td>
<td>$355</td>
<td>$92</td>
<td>$183</td>
</tr>
<tr>
<td>$20,001-25,000</td>
<td>$155</td>
<td>$237</td>
<td>$319</td>
<td>$82</td>
<td>$165</td>
</tr>
<tr>
<td>$25,001-30,000</td>
<td>$137</td>
<td>$210</td>
<td>$284</td>
<td>$73</td>
<td>$146</td>
</tr>
<tr>
<td>$30,001-35,000</td>
<td>$121</td>
<td>$184</td>
<td>$248</td>
<td>$64</td>
<td>$129</td>
</tr>
<tr>
<td>$35,001-40,000</td>
<td>$103</td>
<td>$158</td>
<td>$213</td>
<td>$55</td>
<td>$110</td>
</tr>
<tr>
<td>$40,001-45,000</td>
<td>$85</td>
<td>$132</td>
<td>$177</td>
<td>$45</td>
<td>$82</td>
</tr>
<tr>
<td>$45,001-50,000</td>
<td>$69</td>
<td>$105</td>
<td>$142</td>
<td>$37</td>
<td>$73</td>
</tr>
<tr>
<td>$50,001-55,000</td>
<td>$52</td>
<td>$79</td>
<td>$106</td>
<td>$28</td>
<td>$55</td>
</tr>
<tr>
<td>$55,001-60,000</td>
<td>$34</td>
<td>$53</td>
<td>$71</td>
<td>$19</td>
<td>$37</td>
</tr>
</tbody>
</table>
When you log on, you can choose from several options:

**Health Risk Appraisal:** As described above, this questionnaire will help you determine your risks and how to improve your health.

**Health Dashboard:** Customize this tab with your personal health information — don’t worry, it’s confidential.

**Health Managers and Trackers:** Track your health and take actions to improve it.

**Health Channels:** Search targeted information on topics such as Women’s Health, Men’s Health, Children’s Health, Senior’s Health, and Parenting.

**Diseases and Conditions:** Get general information on a variety of diseases and conditions.

**Healthy Lifestyles:** Find tips on fitness, nutrition, and safety.

**Tools:** Take Health quizzes, use the health calculators, or look up a drug in the drug dictionary.

**Personal Health Record:** Keep a health diary, set up a calendar of health appointments, or create a record of your prescriptions.
GROUP HEALTH OPTIONS
MEDICAL PLAN CHOICES

You have a choice of three plans allowing you to choose the one best suited to meet your needs. All three plans are provided through Group Health Options, Inc. All of the plans incorporate a combination of deductibles, coinsurance, copays, and pharmacy benefits. We have briefly summarized the plan benefits and rates below. You will find complete summaries of the benefits at the end of this Election Guide.

The first plan, called HMO Only, only provides care through Group Health providers. It does not provide coverage if you seek care from community-based providers who are not part of Group Health’s Managed Health Care Network.

The other two choices are Group Health Options, Inc. Point of Service plans. These plans allow you to seek care from either Group Health’s Managed Health Care Network (MHCN) providers or from community-based providers. You may choose either health care delivery option at any time or for differing episodes of illness or injury except during a scheduled inpatient admission at a non-MHCN facility.

Please notice that all of your plan choices have different deductibles, out-of-pocket costs and monthly premiums.

Domestic partners are eligible for coverage under all three health plan choices. You pay the total premium for your partner’s coverage on an after-tax basis. Information on domestic partner eligibility can be obtained from the Human Resources Department.

2006 Medical Benefit Enhancements

The following benefit enhancements are state mandated and applicable to all three plans:

• Copayments and coinsurance for mental health services will be the same as those for medical services provided under the plan.
• Acupuncture benefits will increase from 5 to 8 visits per diagnosis per calendar year.
• Naturopathic benefits will increase from 2 to 3 visits per diagnosis per calendar year.
• The maximum benefits allowance for chemical dependency will increase from $12,500 to $13,000 per member per any 24 consecutive calendar month period.

Waiving Medical Benefits

You may elect not to enroll in the university-sponsored plan only if you have group medical coverage for yourself through an outside plan, such as through your partner’s employer. You must certify that you have such coverage.
### Table 2 - Group Health Options Coverage

<table>
<thead>
<tr>
<th>Coverage Categories</th>
<th>HMO Only</th>
<th>Options High Deductible</th>
<th>Options Low Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yourself</td>
<td>$321.32</td>
<td>$275.03</td>
<td>$335.30</td>
</tr>
<tr>
<td>You/Spouse</td>
<td>$702.02</td>
<td>$600.88</td>
<td>$732.55</td>
</tr>
<tr>
<td>You/1Child</td>
<td>$524.52</td>
<td>$448.95</td>
<td>$547.33</td>
</tr>
<tr>
<td>You/2+Children</td>
<td>$727.66</td>
<td>$622.83</td>
<td>$759.31</td>
</tr>
<tr>
<td>You/Spouse/1Child</td>
<td>$905.20</td>
<td>$774.79</td>
<td>$944.57</td>
</tr>
<tr>
<td>You/Spouse/2+Children</td>
<td>$1,108.37</td>
<td>$948.70</td>
<td>$1,156.59</td>
</tr>
</tbody>
</table>

* Includes the Welcome Rider, which allows 4 office visits (per person) per calendar year at $15 each before it is necessary to satisfy the annual deductible.
PREMERA BLUE CROSS
DENTAL PLAN

Premera Blue Cross allows you to obtain care from either participating dentists or non-participating dentists. The choice is yours any time you need dental care.

You will receive the maximum benefits from this plan if you receive dental services from a participating dentist. Participating dentists have agreed not to bill for any difference in the dentist's normal fees and Premera's allowable charges. You pay only your annual deductible and/or coinsurance amount for covered services and nothing more.

If you choose a non-participating dentist, your out-of-pocket expenses will include any amount charged that exceeds the Premera allowable charge in addition to your annual deductible and/or coinsurance amount for covered services. Also, you may be required to submit claim forms when using non-participating dentists, whereas participating dentists will bill Premera directly. See Table 3 on page 5 for monthly costs.

Dental Plan Option
You may enroll in the dental plan even if you do not enroll in the medical plan. You may choose to use a portion of your benefits allowance or pretax payroll deductions to purchase dental coverage. You may decide not to enroll in the dental plan, whether or not you have other dental coverage, unlike the medical plan.

Covered Dental Services
Dental services are provided with a $50 annual deductible per enrollee ($150 per family) applicable to Basic and Major Services, a 20% coinsurance on basic services and a 50% coinsurance on major services, which you pay directly to your dentist. The following summary briefly describes the benefits of this plan.

Preventive and Diagnostic Services are covered at 80% (not subject to annual deductible):
- Oral exams (two per calendar year)
- Dental X-rays
- Topical Fluoride application for children under the age of 20 (two per calendar year)
- Prophylaxis (two per calendar year)
- Space maintainers for children under the age of 20
- Sealants (on permanent teeth) for children under the age of 14

Basic Services are subject to the annual deductible and covered at 80%:
- Emergency palliative treatment
- Simple fillings
- Extractions
- Endodontics (root canals)
- Oral surgery
- Periodontics

Major Services are subject to the annual deductible and covered at 50%:
- Repair of crown, inlays, dentures, or bridges
- Inlays and onlays
- Crowns
- Bridges, fixed and removable
- Dentures, full and partial
- Relining of dentures

All covered services are subject to a calendar year maximum of $1,000 per enrollee.

Orthodontia benefits are covered at 100% of the allowable charges up to a lifetime maximum of $1,000 for each enrollee.
- 100% up to $250 for diagnostic services, including examination, orthodontic records, and initial banding of the teeth.
- 100% up to $50 of the care provider’s monthly charges up to the benefit maximum.

<table>
<thead>
<tr>
<th>Coverage Categories</th>
<th>Monthly Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yourself</td>
<td>$46.30</td>
</tr>
<tr>
<td>You/Spouse</td>
<td>$91.37</td>
</tr>
<tr>
<td>You/Child(ren)</td>
<td>$104.09</td>
</tr>
<tr>
<td>You/Spouse/Children</td>
<td>$149.14</td>
</tr>
</tbody>
</table>
THE STANDARD GROUP LIFE INSURANCE

The university provides you with $25,000 of group life insurance coverage as a basic benefit. You may choose to use a portion of your benefits allowance or pretax payroll deductions to purchase additional coverage.

You can purchase additional life insurance protection up to $150,000.

The design is as follows:

- Option I $10,000
- Option II $25,000
- Option III $50,000
- Option IV $100,000
- Option V $150,000

If you elect an additional amount above $25,000 (Options III, IV and V) you will be responsible for paying income taxes on the value of this coverage, to the extent that the total value of your basic and optional life insurance coverage exceeds $50,000. This “imputed income” will be reported on your W-2.

If you are currently enrolled in the optional plan, you can only increase your coverage one level without having to provide proof of insurability. For example, if you currently purchase an additional $25,000 of life insurance, you can increase to $50,000 without having to provide proof of insurability. If you elect an amount of insurance that is two or more levels greater than the option you are currently insured for, you are required to furnish proof of insurability by completing a health statement included in the forms section of this booklet and forwarding it to Standard Insurance Company before the greater amount of insurance can become effective.

A change in family status allows you to elect Option I through Options IV without completing the statement.

**Evidence of insurability is always required when making a first-time election for Option V ($150,000).** See Table 4 for monthly costs.

**MEDEX Travel Assist:** Through an arrangement with MEDEX Assistance Corporation, you have access to a comprehensive range of professional 24-hour medical, legal and travel assistance information and coordination services. These services help you plan travel and respond to emergencies that occur 100 miles or more from home and in foreign countries.

### Table 4 - Additional Standard Life Insurance Monthly Costs

<table>
<thead>
<tr>
<th>Age</th>
<th>Option I $10,000</th>
<th>II $25,000</th>
<th>III $50,000</th>
<th>IV $100,000</th>
<th>V $150,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.53</td>
<td>$1.33</td>
<td>$2.65</td>
<td>$5.30</td>
<td>$7.95</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.61</td>
<td>$1.52</td>
<td>$3.05</td>
<td>$6.10</td>
<td>$9.15</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.80</td>
<td>$2.00</td>
<td>$4.00</td>
<td>$8.00</td>
<td>$12.00</td>
</tr>
<tr>
<td>35-39</td>
<td>$1.05</td>
<td>$2.63</td>
<td>$5.25</td>
<td>$10.50</td>
<td>$15.75</td>
</tr>
<tr>
<td>40-44</td>
<td>$1.39</td>
<td>$3.48</td>
<td>$6.95</td>
<td>$13.90</td>
<td>$20.85</td>
</tr>
<tr>
<td>45-49</td>
<td>$2.23</td>
<td>$5.58</td>
<td>$11.15</td>
<td>$22.30</td>
<td>$33.45</td>
</tr>
<tr>
<td>50-54</td>
<td>$3.77</td>
<td>$9.43</td>
<td>$18.85</td>
<td>$37.70</td>
<td>$56.55</td>
</tr>
<tr>
<td>55-59</td>
<td>$6.26</td>
<td>$13.65</td>
<td>$31.30</td>
<td>$62.60</td>
<td>$93.90</td>
</tr>
<tr>
<td>60-64</td>
<td>$10.30</td>
<td>$25.75</td>
<td>$51.50</td>
<td>$103.00</td>
<td>$154.50</td>
</tr>
<tr>
<td>65-69</td>
<td>$17.18</td>
<td>$42.95</td>
<td>$85.90</td>
<td>$171.80</td>
<td>$257.70</td>
</tr>
<tr>
<td>70-74</td>
<td>$28.62</td>
<td>$71.55</td>
<td>$143.10</td>
<td>$286.20</td>
<td>$429.30</td>
</tr>
<tr>
<td>75-79</td>
<td>$51.45</td>
<td>$128.63</td>
<td>$257.25</td>
<td>$514.50</td>
<td>$771.75</td>
</tr>
<tr>
<td>80 and over</td>
<td>$85.90</td>
<td>$214.75</td>
<td>$429.50</td>
<td>$859.00</td>
<td>$1,288.50</td>
</tr>
</tbody>
</table>
PERSONAL EXPENSE ACCOUNTS

Using an expense account is a three-step process:

Step 1
Estimate the amount of eligible health care expenses and eligible dependent care expenses you expect to have for the calendar year, and estimate the amount that will be paid by other sources, such as your medical insurance. Then decide how much you want to contribute to a Health Care Expense Account for eligible health care expenses, or a Dependent Care Expense Account for eligible dependent care expenses. Your contributions can be in the form of your allowance from the university or deductions from your pay before taxes are deducted, or a combination of these. If you did not enroll in the medical plan, then your allowance from the university first will be used to pay for your dental and/or group life insurance coverage, if elected; the remainder must be deposited in one or both of your expense accounts, at your direction. You may deposit additional amounts through pretax payroll deduction up to certain limits.

The advantage is this: when money goes into an expense account, it is like a “tax deduction” from your paycheck. When money is paid out to you from your expense account, it is not considered to be taxable income. Therefore, you use pretax salary dollars to pay expenses you would otherwise be paying with after-tax salary dollars.

Warning: Federal tax laws require that money deposited in an expense account may be paid out ONLY to reimburse eligible expenses incurred in the same calendar year. If money is left over in an account after the end of a calendar year, IT MUST BE FORFEITED. So, if you use an expense account, you should estimate carefully what your eligible expenses will be during the calendar year.

Step 2
Keep track of your eligible health care and/or dependent care expenses.

Step 3
From time to time during the year, you submit a claim and receive reimbursement from your expense account with tax-free dollars. You may file a claim up to the total amount you have elected to deposit in the Health Care Account, even if the full amount has not yet been withheld from your paycheck.

Once you have been reimbursed for the total amount you elected to contribute for the year, no further reimbursements will be made. However, contributions from your paycheck will continue until you have contributed the entire amount you elected for the year.

Deposits To An Expense Account
On your Election Form, you need to indicate just how much money, if any, you want to deposit in each of your two expense accounts.

- Health Care has no maximum amount per year.
- Dependent Care maximum is $5,000 per year. ($2,500 per year if you are married but file a separate tax return).

You may not increase, reduce, or stop your expense account deposits during the year unless you have a qualifying family status change. See page 8 under Making Changes in the Future for more information. Balances in expense accounts do not earn interest.

Filing Expense Account Claims
Under both accounts, claims are submitted to Integrity Administrators, P.O. Box 13128, Sacramento, CA 95813-3128. Reimbursement checks are issued twice per week and mailed directly to your home address. If you have questions about your claims, please call 800.562.9383, ext. 313. Claim forms with full instructions and addressed envelopes are available from Human Resources.

The university is not responsible for the postage to mail your claims to Integrity Administrators. Mail Services will return all envelopes to the sender for proper postage. When envelopes do not have a return address, Mail Services will forward the envelope to Human Resources where they will be opened and returned to the sender for proper postage.

What Are “Eligible Expenses”?
Certain kinds of health care expenses can be reimbursed from your Health Care Expense Account. And certain daycare expenses for your dependents can be reimbursed from your Dependent Care Expense Account. You cannot “cross over” from one account to the other; expenses can be reimbursed only from the proper account.

What are “eligible expenses”? Here are some general rules:

- They must be incurred between January 1 and December 31. However, you can submit claims for services during the year for which you established the account until March 31 of the following calendar year.
They meet IRS requirements.
In the case of the Health Care Expense Account, you are not eligible to receive reimbursement from any other source, such as through your spouse’s health plan.
You cannot claim the same expenses on your tax return at the end of the year.

**Eligible Health Care Expenses**
The Health Care Expense Account is designed to reimburse you for health care expenses incurred by you and all members of your family who are your dependents for federal income tax purposes. Here are the types of expenses that can qualify:

- Medical deductibles, coinsurance, and copayments (the portion of medical charges you pay).
- Dental deductibles and copayments.
- Most medical expenses not covered by a medical plan, such as hearing aids, glasses, contact lenses, and non-prescription drugs.
- Most dental expenses not covered by a dental plan.

You cannot pay for premiums for other health care plans (such as your spouse’s) through your Health Care Expense Account. For more information about eligible expenses and non-eligible expenses, see Internal Revenue Service Publication 502, Medical and Dental Expenses. The publication is available from a public library, local IRS office or the IRS Web site (www.irs.gov).

**Health Care Expenses Not Eligible**
The following are some examples of expenses that are not eligible for reimbursement from the Health Care Expense Account:

- Cosmetic surgery, unless required to treat an illness, injury, or deformity arising from a congenital abnormality.
- Funeral and burial expenses.
- Household and domestic help.
- Custodial care in an institution.
- Health club dues.

You may use the Dependent Care Expense Account if you require daycare services for certain dependents so you can work. If you are married, your spouse must either be employed outside the home, disabled, or a full-time student.

**Eligible expenses are:**

- Charges for the care of your children, aged 12 and under. You must be able to claim a dependent exemption for that child on your federal income tax return.
- Charges for the care of children or adults of any age who are unable to care for themselves because of physical or mental disability. A person qualifying for this type of care must spend at least eight hours a day in your home and the child must be your dependent for federal income tax purposes. Nursing home expenses do not qualify.

To be eligible for reimbursement through an expense account, the care cannot be provided by your spouse, your child under age 19, or anyone you claim as a tax dependent. If the services are provided at a center that cares for six or more people, the facility must comply with all state and local laws. You’ll have to provide the name, address, and Social Security Number (or other taxpayer identification number) of your care provider on your federal income tax forms at the end of the year. The IRS will allow an exception only if your care provider is a church or other religious or charitable organization under Section 501(c)(3) of the Internal Revenue Code.

You cannot claim reimbursement through a Dependent Care Expense Account and claim the same expenses as a tax credit on your income tax return. The expense for which you may claim the tax credit will be reduced by one dollar for each dollar of reimbursement you receive from the Dependent Care Expense Account.

You may not be able to deposit the maximum available under this expense account if either of these situations applies to you:

- If either you or your spouse earns less than $5,000 in annual taxable income, you would be able to deposit only as much as the lower of the two earned incomes. If your spouse is either a full-time student or incapable of self-care, each month that either of these conditions applies, your spouse will be considered to have an income of $200 a month if care is provided for one dependent, or $400 a month if care is provided for two or more.
- If you are married but file a separate tax return, you may deposit a maximum of $2,500 in the Dependent Care Expense Account.
Expenses Not Eligible
The following are examples of expenses that are not eligible for reimbursement through the Dependent Care Expense Account:

- Expenses for food, clothing, overnight camp, entertainment, and education beginning when your qualified dependent enters the first grade.
- Expenses for dependent care so that your spouse can perform volunteer work.
- Transportation expenses.
- Charges for a convalescent nursing home.

For more information about eligible and non-eligible expenses, see IRS Publication 503, Child and Dependent Care Expenses, available from a public library, local IRS office or the IRS Web site (www.irs.gov).

Tax Credit vs. Personal Expense Account For Dependent Care Expenses
Because many dependent care expenses can either be paid through your Personal Expense Account or claimed as a tax credit when you file your federal income tax return (but not both), you may want to investigate which alternative produces the better financial result for you.

Which should you use? Tax credit or spending account? The precise answer depends on a number of factors, including the number of dependents you have, the amount of your annual expenses, and your tax filing status. Generally, if your household's total adjusted annual income is greater than $39,000, you should consider using the Dependent Care Expense Account.

If you have two or more qualifying dependents and have $6,000 or more in qualifying dependent care expenses per calendar year, you may want to consider utilizing the Dependent Care Expense Account for the maximum election amount of $5,000.

The remaining $1,000 may be claimed on your tax return under the Child Care Tax Credit. Please confer with your tax advisor to be sure whether a tax credit, an expense account, or splitting the expenses between the two will result in greater tax savings for you.

When Personal Expense Account(s) Participation Ends
Your participation in the expense accounts will end on the earliest of:

- The date you are no longer employed by the university.
- The date the expense accounts are terminated by the university.
- The date you are no longer eligible for participation in the accounts.

When any of the above events occurs, all pretax contributions to your expense accounts will end. Expenses incurred from that date forward will not be eligible for reimbursement. You have three months after the cancellation of your accounts to submit claims incurred during your period of coverage.

Other Leaves of Absence
If you are on a paid leave of absence, your expense account participation continues during the time you are on leave. You continue to make contributions through payroll deduction. You may continue to file claims for eligible expenses. If you are on an unpaid leave (other than FMLA leave), your expense account participation continues during the time that you are on leave only if you make the required contributions on an after-tax basis.

If You Retire While Participating
If you retire while participating in the expense accounts, your participation will end on the date you are no longer employed by the university. Expenses incurred from that date forward will not be eligible for reimbursement. You have three months after the cancellation of your account to submit claims incurred during your period of coverage.

Your Dependent Care Expense Account participation may not be continued under COBRA.

If You Die While Participating
If you die while participating in the expense accounts, your participation will end on the date of your death. Your surviving dependents can submit claims for eligible expenses incurred through the date of your death.
COBRA Continuation
If coverage under the Health Care Expense Account ends because you did not return to work at the end of your FMLA leave, you terminated employment, or you died, you or your dependents may be able to elect continuation of the Health Care Expense Account coverage for the rest of the year by making after-tax contributions. See page 11, Continued Benefits Coverage Under COBRA for more information. Your Dependent Care Expense Account participation may not be continued under COBRA.

Expense Account Decisions for 2006
Should you deposit money to one or both expense accounts? Here are some questions to ask yourself before you decide:

1. Do I plan to incur expenses during the year that would be eligible for reimbursement (such as daycare expenses or medical and dental plan deductibles)?
2. Can I make a fairly accurate prediction of the eligible health care or dependent care expenses my family will have during the year, so I avoid any forfeitures at the end of the year?
3. How much can I afford to deposit during the year without affecting my ability to meet day-to-day expenses?

THE NEXT STEPS
Fill out Forms!

- **You must fill out the Flexible Benefits Election Form.**
- **You must fill out the Flexible Benefits Application or Waiver of Coverage Form.**
  - You must complete the Health Risk Appraisal to receive the allowance incentive.
  - You must complete a health statement if you are increasing optional life insurance coverage two or more levels or if you are increasing to Option V ($150,000).
  - You must complete an allowance subsidy application, if you are eligible for a subsidy.

All applicable forms must be submitted to Human Resources.

MAKING CHANGES IN THE FUTURE

Special Enrollment Period Rules
You are eligible for a special enrollment period for medical or dental benefits if you or your dependents who declined coverage under the university-sponsored medical or dental plans because of other group health coverage subsequently lose that other group coverage. In addition, new dependents are also eligible to enroll in a university-sponsored medical or dental plan under the special enrollment period rules.

Special Enrollment After Loss of Eligibility for Other Health Coverage
The following rules must be met in order to qualify for special enrollment:

- You and/or your dependents must be otherwise eligible for coverage under the flexible benefits plan.
- At the time coverage was declined, you and/or your dependents must have had other group health care coverage.
- The plan may require a written declaration at the time the coverage is declined.

**You and your dependents may enroll:**

- If you declined coverage because of COBRA coverage and such coverage has been exhausted.
- You and/or your dependents lose coverage due to loss of eligibility or if the employer ceases to make any contributions.

**The following will disqualify you for special enrollment:**

- Coverage is lost due to failure to pay premiums or for cause.
- You and/or your dependents do not request special enrollment within 30 days after termination of coverage.

Coverage must begin no later than the first day of the month following your request for special enrollment.

Special Enrollment for New Dependents
The plan offers a special enrollment period for certain new dependents. A new dependent due to marriage, birth, adoption, or placement for adoption triggers a special enrollment period for each new dependent and your spouse, if your spouse is eligible but unenrolled in the plan.

The following rules must be met in order to qualify for special enrollment:

- The special enrollment request must be made within 30 days of the qualifying event.
- You, your spouse and/or your new dependent must be allowed to enroll during the special enrollment period.
- In the case of a dependent acquired through marriage, coverage must begin no later than the first day of the month following the date you request special enrollment.
- In the case of birth, adoption, or placement for adoption, coverage begins on the date the event occurred.
CONTINUED BENEFITS
COVERAGE UNDER COBRA

When coverage under the medical plan, the dental plan, or the health care expense account would otherwise end, you and your enrolled dependents may extend your coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). You pay the full monthly premium for extended coverage, plus a 2 percent administrative fee.

You may extend coverage for yourself and your dependents for up to 18 months if you lose coverage because of one of the following qualifying events:

- Your employment with the university is terminated for any reason other than for gross misconduct.
- Your hours are reduced below the minimum number of hours that makes you eligible for coverage.

Your spouse or your dependent children may extend their coverage for up to 36 months if they lose coverage because of one of the following qualifying events occurs:

- You and your spouse legally separate or divorce.
- You become entitled to receive benefits under Medicare.
- Your dependent child loses eligibility.
- Your death.

In addition, if another qualifying event occurs while you are covered under COBRA, the following applies:

- The COBRA coverage period begins on the date of the first qualifying event; and
- The number of months of COBRA coverage is determined by the event with the longer coverage period. Only one period applies; the different coverage periods are not added together.

The 18 month period of coverage may be extended an extra 11 months if you or a covered family member is determined disabled by Social Security within 60 days of the commencement of coverage. To obtain the extension you must notify Human Resources within 60 days of the date the determination is made and before the end of the initial 18-month coverage period. In this case, you may be eligible for up to 29 months of COBRA coverage. You will be charged up to 150 percent of the cost for the 11-month extension of coverage.

How To Elect Extended Coverage
You or your dependents must notify Human Resources if coverage ends due to divorce or if a dependent loses eligibility. To be valid, you must notify Human Resources within 60 days of the event or at the time coverage ends, whichever is later.

In other circumstances, Human Resources will notify you that you may elect continued coverage. When you are notified, you will receive a more detailed explanation of your COBRA rights and an application form.

You have 60 days to elect continued coverage from the date you are notified of your eligibility or the date your group coverage ends, whichever is later. You then have 45 days from the date you submit your application to make your first payment.

When Coverage Ends
COBRA coverage for you or your dependents will end before the end of your 18-month, 29-month, or 36-month coverage period if:

- The required premiums are not paid on time.
- Coverage is obtained after electing COBRA under Medicare.
- Coverage is obtained after electing COBRA under another group health or dental plan, unless the new plan has a pre-existing condition clause that limits coverage for the individual continuing coverage.
• The university terminates all group health plans for all faculty and staff members.

When your COBRA coverage ends, you will be able to convert to an individual medical or dental policy. Individual coverage is not available for the Health Care Expense Account.

Your COBRA rights are subject to change. Coverage will be provided only as provided by law; if the law changes, your rights will change accordingly.

**ADMINISTRATIVE INFORMATION ABOUT YOUR BENEFITS**

Here is additional information about your benefits.

**Plan Sponsor**
The University of Puget Sound is the employer whose faculty and staff members are covered by the Flexible Benefits Plan. The university’s address is:

The University of Puget Sound
1500 N. Warner St. #1064
Tacoma, WA  98416-1064

**Plan Administrator**
The address and phone number for the plan administrator is:

The University of Puget Sound
1500 N. Warner St. #1064
Tacoma, WA 98416-1064

Human Resources has day-to-day responsibility for plan administration. You can reach Human Resources by calling 253.879.3369.

**Employer Identification Number**
The Employer Identification Number is 91-056961.

**Plan Name**
The name of the plan is the University of Puget Sound Flexible Benefits Plan.

**Plan Number**
The plan number is 507.

**Plan Type**
The University of Puget Sound Flexible Benefits Plan is a Welfare Benefit Plan.

**Plan Year**
The plan year, for record keeping purposes, is January 1 through December 31.

**Type of Administration**
Group Health Options, Inc. Premera Blue Cross, and The Standard Insurance Company provide claims administration and other services for the medical, dental, and life insurance plans. Integrity Administrators, Inc. provides administration for the Flexible Spending Account Programs.

**Source of Contributions**
The university and faculty and staff members contribute to the plans.

**Source of Benefit Payments**
Medical, dental, and life insurance benefits are paid by the carriers through insurance contracts.

Health Care Expense Account and Dependent Care Expense Account benefits are paid from the university’s general assets.

**Agent for Service of Legal Process**
The agent for service of any legal process on the Flexible Benefits Plan is:

Secretary of the Corporation
The University of Puget Sound
1500 N. Warner St., CMB #1064
Tacoma, WA  98416-1064

**Future of the Plans**
Changes to the Plan and the Personal Expense Accounts may be made by and with the approval of the appropriate officers of the university.

Although the university expects to continue the plans described in this booklet indefinitely, the university reserves the right to amend, alter, delete, cancel, terminate, or otherwise change the plans or any of the provisions of the plans at any time and for any reason.

**No Guarantee of Employment Rights**
Nothing in this summary says or implies that participation in the university’s benefits plans is a guarantee of continued employment with the university. The fact that the plans are available and that you participate in them also does not interfere with the right of the university to discharge you at any time.

**No Contract**
The fact that the university provides these benefits to you, and your participation in the plans, does not create a contract between the university and you.

**Plan Documents Govern**
This booklet is a summary of some features of the Flexible Benefits Plan. Details on the medical, dental, and life insurance benefits are provided in separate booklets. Those booklets, together with this booklet, constitute the summary plan description for the Flexible Benefits Plan. This booklet is not intended to contain all details of the plans. The details are in the contracts and official plan documents. In case of a discrepancy between this booklet and the contracts and documents, the contracts and documents would govern benefits paid by the plan.
STATEMENT OF YOUR
LEGAL RIGHTS

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

• Examine, without charge, at the plan administrator’s office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
• Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
• Receive a summary of the Plan’s annual financial report.

The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. In addition to creating rights for Plan participants, ERISA imposes duties upon 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored in whole or in part you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

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

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 Area 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, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Administration.