The Election Guide briefly summarizes the benefit program choices provided by the university and is based on current university programs, policies, and practices. This statement does not contain detailed information regarding the various benefits described. For detailed information, you should consult the plan documents and insurance booklets. If the text of this statement is inconsistent with the plan document or insurance booklets, the language in the plan document or insurance booklet controls. The university reserves the right, whether in an individual case or more generally, to alter, reduce, or eliminate any pay practice, policy, or benefit, in whole or in part, without notice. University of Puget Sound is an equal opportunity, affirmative action employer and educator.

Enrollment instructions on inside cover
IF YOU ARE NEWLY ELIGIBLE FOR BENEFITS
ACTIONS REQUIRED WITHIN 30 DAYS OF HIRE

If you are a faculty or staff member who is newly eligible for flexible benefits, you have 30 days from your date of hire (or date of appointment to an eligible position) to select benefits.

1. Review this Election Guide for a summary of the benefits offered as part of this plan and to determine the benefits that are best suited to meet the needs of you and your family in 2014.

2. Complete your 2014 Benefits Election and Enrollment Form. Make sure to sign in all applicable signature locations.

3. Submit your 2014 Benefits Election and Enrollment Form to Human Resources (deliver in person to Howarth Hall 016, send through campus mail to CMB #1064, or scan and email to hr@pugetsound.edu). Please also include the following forms, if they are applicable to you:
   - Affidavit of Marriage or Domestic Partnership Form (required if you are enrolling your spouse, domestic partner or the child of a domestic partner for a benefit for the first time)
   - Unum Beneficiary Designation Form (optional, but strongly recommended)

If you do not take action within 30 days from your date of hire (or date of appointment to an eligible position), your enrollment will automatically default to the High Deductible HRA medical plan for yourself only with no other coverage. After your election period is over, you will not have the opportunity to make changes to your benefits until next year’s open enrollment, unless you experience a qualifying status change during the year. Refer to pages 19-20 for more details.

If you need assistance, contact Human Resources at 253.879.3369 or hr@pugetsound.edu, or visit us at Howarth Hall 016 during regular business hours (8 a.m. to noon, 1 - 5 p.m.).
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ELIGIBILITY AND ENROLLMENT PROVISIONS

To be eligible for the university Flexible Benefits Plan, you must be a faculty or staff member with at least a half-time appointment, or a full-time, one-semester visiting faculty member.

- Staff members have half-time appointments when they are in regular positions scheduled to work 1,040 hours per year or .50 FTE over the course of the year.
- 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. Visiting faculty members scheduled to teach three units in one semester are also eligible for these benefits.

Benefits begin the first of the month coinciding with or following date of eligibility.

The following definitions must apply for dependents, spouses or partners to be eligible for the benefits of this plan.

**Spouse** is defined as one to whom a faculty or staff member is legally married. (If you are enrolling your spouse for a benefit for the first time, you must complete an Affidavit of Marriage or Domestic Partnership Form.)

**Partner** is defined as one to whom a faculty or staff member is in a domestic partnership that is registered with the State of Washington and/or is demonstrated by sharing the same regular and permanent residence; sharing an ongoing, personal and committed relationship which they have with no other and which is comparable to marriage; and being jointly responsible for each other's welfare and the maintenance of their household. (If you are enrolling your partner for a benefit for the first time, you must complete an Affidavit of Marriage or Domestic Partnership Form.)

**Dependent child** is defined as an individual under the age of twenty-six (26) who is your natural or adoptive child, stepchild, 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 shall be eligible to remain enrolled beyond the age of twenty-six (26) if you request continued coverage for the child within thirty-one (31) days of the child's twenty-sixth (26th) birthday and provide documentation of disability.
- Foster children are not eligible for coverage.
- If you are enrolling a child of a partner for a benefit for the first time, you must complete an Affidavit of Marriage or Domestic Partnership Form.

**NEWLY ELIGIBLE:** If you are a faculty or staff member who is newly eligible for flexible benefits, you have 30 days from your date of hire (or date of appointment to an eligible position) to select benefits. **If you do not take action during this time, your enrollment will automatically default to the High Deductible HRA medical plan for yourself only with no other coverage.**

After your election period is over, you will not have the opportunity to make changes to your benefits until next year's open enrollment, unless you experience a qualifying status change during the year. Refer to pages 19-20 for more details.

**PREMIUMS FOR NON-EXEMPT STAFF SCHEDULED TO WORK LESS THAN 12 MONTHS**

Note that all premiums listed in this election guide and in accompanying benefit materials reflect the standard monthly premium for employees who are scheduled to work and pay for benefits during all 12 months of the calendar year. Staff members in positions that are non-exempt from the Fair Labor Standards Act and who are scheduled to work less than 12 months during the calendar year will pay for their benefits on a prorated basis during the 9-month academic year, from January 1 through May 31 and again from September 1 through December 31. The proration formula is:

\[
\text{Adjusted premium per month} = \frac{\text{Standard monthly premium} \times 12}{\text{9 months}}
\]

An example using a benefit with a standard monthly premium of $36:

\[
\frac{36 \times 12}{9} = \frac{432}{9} = 48 \text{ per month during the academic year}
\]
In 2014, the university will offer two medical plan options:

- **High Deductible Plan with Health Reimbursement Arrangement (HRA):** This plan has an annual in-network deductible of $1,500 per individual / $3,000 per family and includes a university-funded health reimbursement arrangement that can be used to help participants pay for the qualified medical deductible. (This is a change from prior years in which HRA funds were available for medical, dental, prescription and vision expenses.) The university will contribute $750 to an HRA if the faculty/staff member alone is enrolled in the High Deductible HRA plan and $1,500 if at least one other family member is also enrolled. If you enroll during the plan year, the amount provided is prorated based on the number of months you are enrolled in the plan during the calendar year.

- **Low Deductible PPO Plan:** This plan has an annual in-network deductible of $200 per individual / $600 per family and does not include access to a university-funded HRA account.

**University Premium Contributions**
For the High Deductible HRA plan, the university will contribute 100 percent of the premiums for faculty/staff coverage, 50 percent for dependent child(ren) coverage, and 25 percent for spouse/partner coverage. The Low Deductible PPO plan is considered a buy-up option for faculty and staff who wish to purchase a low deductible plan; faculty and staff members will pay more towards premiums under this plan than under the High Deductible HRA plan.

**Preventive Services**
Preventive care services require no cost share from the participant (not subject to deductible or copay). The list of covered preventive care services has been expanded in recent years and includes coverage for annual exams, mammograms, some birth control, well-baby and newborn exams, and many other services. For specific information, log in to your Premera account or visit [premera.com/wa/member/stay-healthy/preventive-health/](http://premera.com/wa/member/stay-healthy/preventive-health/).

**Prior Authorization**
Starting September 1, 2013, Premera has **new** prior authorization requirements for certain services, such as the following:

- Planned admission into hospitals or skilled nursing facilities
- Non-emergency ground or air ambulance transport
- Advanced imaging, such as MRIs and CT scans
- Transplant and donor services
- Some planned outpatient procedures
- Some injectable medications you get in a health care provider’s office
- Prosthetics and orthotics other than foot orthotics or orthopedic shoes
- Reconstructive surgery
- Home medical equipment costing $500 or more

To avoid extra costs, always ask your health care provider to request a prior authorization before you have a planned medical service. Without a prior authorization, you may have to pay more. For more information, visit [premera.com/wa/member/my-premera-plan/make-sure-you-are-covered/](http://premera.com/wa/member/my-premera-plan/make-sure-you-are-covered/).

**Premera Discount Programs**
As a Premera member, you have access to discounts for newborn services and products, alternative care, hearing aids/screenings, fitness clubs and gyms, diet and nutrition, and eye care services and hardware. To see a detailed list of discounts available, visit [premera.com/wa/member/stay-healthy/member-discounts/](http://premera.com/wa/member/stay-healthy/member-discounts/).

**Form W-2 Reporting**
The total value of your 2013 medical coverage premiums will be included on your 2013 Form W-2 that you will receive in January 2014. This information is included strictly for informational purposes as required by the Affordable Care Act and does not impact your income or taxes.
**Premera Blue Cross Medical Plan Choices**

University of Puget Sound offers you a choice of two medical plans through Premera Blue Cross: the High Deductible Plan with a Health Reimbursement Arrangement (HRA) and the Low Deductible PPO Plan. Although both plans cover the same medical services, they are different in two important ways: how much you pay in payroll deductions and how much money you spend when you receive services. To decide which plan is best for you, consider your and your family’s health care needs and your budget.

Both plans allow care from either in- or out-of-network providers. You will have greater benefits and pay less if you choose an in-network provider.

To find a Premera provider:
1. Go to [www.premera.com](http://www.premera.com)
2. Click “Find a doctor”
3. Click “Find doctors/professionals” or “Find a dentist”
4. Choose the search option that best meets your needs
   a. Puget Sound’s network is called “Heritage & Heritage Plus 1”
   b. Puget Sound’s prefix is “ZKR”
   c. Select additional criteria you would like to use in your search for a provider (e.g., accepting new patients, male/female, board certified, extended office hours)

---

<table>
<thead>
<tr>
<th>Table 1 – Medical Plan Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
</tr>
<tr>
<td>Annual Deductible</td>
</tr>
<tr>
<td>University’s HRA Contribution</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Includes Deductible)</td>
</tr>
<tr>
<td>Preventive Care*</td>
</tr>
<tr>
<td>Office Visit</td>
</tr>
<tr>
<td>Emergency Room</td>
</tr>
<tr>
<td>Prescription</td>
</tr>
<tr>
<td>Prescription</td>
</tr>
<tr>
<td>Retail (30-day supply)</td>
</tr>
<tr>
<td>Mail Order (90-day supply)</td>
</tr>
<tr>
<td>Vision Exam</td>
</tr>
</tbody>
</table>

* For specific information about what is included in preventive care services, log in to your Premera account or visit [premera.com/wa/member/stay-healthy/preventive-health/](http://premera.com/wa/member/stay-healthy/preventive-health/).

For additional information about medical plan benefits, you may also refer to the Summary of Benefit and Coverage, which offers a simple side-by-side comparison of the two plans.

**High Deductible HRA Plan**

Before the plan pays benefits for a covered person each plan year, the individual must pay the first $1,500 of eligible in-network medical expenses for non-preventive services. This amount is called the annual deductible. The maximum annual in-network deductible for family coverage is $3,000. To help you pay the deductible, the university will contribute funds to a Health Reimbursement Arrangement (HRA). Pages 8-10 contain more information about how the HRA works. Once you have met your deductible, you will pay a percentage of the expenses, called coinsurance. If your coinsurance and deductible reach the out-of-pocket maximum, the plan will pay 100 percent of your eligible expenses for the rest of the plan year, excluding copayments. **This plan has a**
higher deductible but you pay less towards premiums out of each paycheck (vs. the Low Deductible PPO Plan).

**Low Deductible PPO Plan**
The Low Deductible PPO Plan has a $200 in-network deductible for individual coverage and a maximum of $600 in-network deductible for family coverage. Once you have met your deductible, you then pay a percentage of the expenses, called coinsurance. If your coinsurance and deductible reach an amount called the out-of-pocket maximum, the plan will pay 100 percent of your eligible expenses for the rest of the plan year, excluding copayments. **This plan has a lower deductible but you pay more towards premiums out of each paycheck (vs. the High Deductible HRA Plan).**

**Waiving Medical Benefits**
You may elect not to enroll in a university-sponsored plan only if you have adequate medical coverage for yourself through another plan, such as through your spouse’s or domestic partner’s employer or through an ACA-sponsored health plan. To waive university medical benefits, you must attest that you have such coverage. Otherwise, you must enroll in one of the two medical plans offered by the university.

**2014 Medical Plan Costs by Coverage Category**
The following are 2014 monthly costs for each of the two Premera Blue Cross medical plans:

<table>
<thead>
<tr>
<th>Table 2 – Monthly Medical Plan Costs</th>
<th>Premium Total</th>
<th>Faculty &amp; Staff Share*</th>
<th>Puget Sound Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Deductible HRA Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You</td>
<td>$510</td>
<td>$0</td>
<td>$510</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
<td>$1,147</td>
<td>$478</td>
<td>$669</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
<td>$893</td>
<td>$191</td>
<td>$702</td>
</tr>
<tr>
<td>You, Spouse/Partner &amp; Child(ren)</td>
<td>$1,530</td>
<td>$637</td>
<td>$893</td>
</tr>
<tr>
<td><strong>Low Deductible PPO Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You</td>
<td>$664</td>
<td>$107</td>
<td>$557</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
<td>$1,494</td>
<td>$731</td>
<td>$763</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
<td>$1,162</td>
<td>$366</td>
<td>$796</td>
</tr>
<tr>
<td>You, Spouse/Partner &amp; Child(ren)</td>
<td>$1,992</td>
<td>$1,005</td>
<td>$987</td>
</tr>
</tbody>
</table>

*Semi-monthly payroll deductions will be equivalent to half of the premium listed.

Faculty and staff members pay their portion of costs on a pretax basis. However, due to IRS regulations, medical premiums for your domestic partner (DP) and for the dependent children of your DP are taken on an after-tax basis. You will also be charged imputed income for the coverage of your DP and your DP’s dependents. Imputed income is calculated as the value of the university’s contribution to their premium. This value is added to your gross salary as though you received it as income, and then taxed. If two individuals enter into a legally recognized marriage and the spouse is eligible for group health plan coverage, the employee will not be taxed on that coverage under federal income tax laws. In addition, the employee can pay for the spouse’s coverage on a pretax basis.

**How the Health Reimbursement Arrangement (HRA) Works**
At the beginning of the plan year (January 1), if you are enrolled on the High Deductible Medical Plan the university deposits funds in an HRA for you. The university's 2014 contribution to your HRA is based on the level of coverage you elect in the High Deductible HRA Plan (the HRA is not available to those who enroll on the Low Deductible PPO Plan):

- Employee only enrollment: Up to $750 (account may not exceed the full in-network individual deductible)
- Family enrollment: Up to $1,500 (account may not exceed the full in-network family deductible)

If you enroll during the plan year, the amount deposited is prorated based on the number of months you are enrolled in the plan. If you don’t use all of your HRA money by the end of the plan year (December 31), the balance will carry over (up to the full in-network deductible) so you can use it in the next plan year.

The IRS does not allow faculty and staff members to contribute to their HRA, but you may choose to participate in a Health Care Flexible Spending Account (FSA) to offset additional eligible out-of-pocket expenses. More information about the Health Care FSA is found on pages 15-19.
HRA funds can be used to help pay the **qualified medical deductible** for you and any dependents that are also enrolled on the High Deductible HRA Plan. Medical deductible payments to Premera in-network providers will automatically be paid from the HRA account (if the HRA account still has funds available at the time of service) and are processed by a company called ConnectYourCare. Claims for the following types of expenses always need to be submitted manually (online, via fax or by mail) in order to receive reimbursement:

- Medical deductible related to certain sensitive conditions (e.g., pregnancy, mental health)
- When you are covered by multiple health plans and need to coordinate benefit coverage
- Claims for your domestic partner

All 2014 claims must be submitted to ConnectYourCare by March 31, 2015.

**Out-of-Pocket Example**

Below is an example of how the High Deductible HRA Plan works for Mary:

- Mary is enrolled in the High Deductible HRA Plan with employee only coverage. Mary has high blood pressure and diabetes.
- As part of keeping the conditions stabilized, she sees her in-network physician annually. Since her visit is to treat chronic conditions, this is not considered a preventive care visit. As a result, this annual visit will be subject to the deductible and coinsurance.
- Mary needs to have lab work done when she goes in for her visit. Lab work services are also subject to the deductible.
- As part of treating the conditions, Mary takes high blood pressure medication and two diabetes medications. Under the plan, Mary is subject to the applicable prescription drug copayments to fill these medications.

See the table below to see why the High Deductible HRA Plan makes sense for Mary.

<table>
<thead>
<tr>
<th>Table 3 – High Deductible HRA Plan Estimated Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Services</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Starting HRA Balance</td>
</tr>
<tr>
<td>Lab Work</td>
</tr>
<tr>
<td>Non-Preventive Office Visit</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>High Blood Pressure Medicine *</td>
</tr>
<tr>
<td>(Preferred Brand)</td>
</tr>
<tr>
<td>Two Diabetes Medications*</td>
</tr>
<tr>
<td>(One generic and one preferred brand)</td>
</tr>
<tr>
<td>Annual Premium (Employee Only)</td>
</tr>
<tr>
<td>Faculty/Staff Member Total Estimated Health Expenses</td>
</tr>
<tr>
<td>Remaining HRA Balance (Rolls over into next plan year)</td>
</tr>
</tbody>
</table>

* Reminder: copayments do not apply to the deductible.

Mary was able to use her HRA dollars to pay for the deductible expenses on the lab work and the office visit. When she combined her total out-of-pocket cost ($840) with the employee premiums ($0), the High Deductible HRA Plan was the right plan for her.

**Coordination between HRA and FSA**

The HRA and Health Care FSA, while separate accounts, provide reimbursement of qualified medical expenses as defined by the university for the HRA (qualified medical deductible only) and by the IRS for the Health Care FSA (i.e., deductibles, coinsurance, and prescription expenses). Should you have both accounts, qualified medical deductible expenses eligible under both plans will be reimbursed through the HRA first, and then applied to the Health Care FSA. The HRA will always pay first, unless the expense is not eligible under the HRA, or if the HRA dollars are depleted. Unlike the HRA, Health Care FSA contributions do not roll over from year to year, so it
is important to think carefully about any Health Care FSA contributions you elect to make to ensure you do not risk forfeiture of your own unused contributions.

If you are also enrolled in a Dependent Care FSA, that completely separate account is not affected by HRA or Health Care FSA reimbursements.

**Prescription Drug Benefits**

Puget Sound faculty and staff members enrolled in one of the Premera medical plans have access to a nationwide network of retail pharmacies and to a convenient mail order pharmacy. The current mail order vendor is Express Scripts, which merged with Medco last year.

| Table 4 – Participating Prescription Copayments |
|-----------------|-----------------|
|                 | Retail (30-day supply) | Mail Order (90-day supply) |
| Generic         | $10              | $20               |
| Preferred Brand | $30              | $60               |
| Non-Preferred Brand | $60        | $120              |

**Retail Pharmacy**

You have access to a comprehensive retail pharmacy network administered by Express Scripts, offering you choice and convenience. For a 30-day supply of prescriptions filled at a participating retail pharmacy, you will pay a copayment based on the type of prescription being filled. Use the Premera provider directory to find participating pharmacies, or call the toll-free pharmacy locator line at 1.800.391.9701.

**Mail Order**

If you take long-term maintenance medication, using the Express Scripts mail order service may save you money and offers you the convenience of delivery through the mail. Through the mail order program, you can get a 90-day prescription supply for the same cost as a 60-day retail supply.

**Important note:** If you are using a *generic* maintenance medication that you refill each month, we encourage you to compare the cost difference between filling this prescription through retail vs. mail order. Some generic medications may be available at lower cost through retailers such as Target, Walmart, etc.

**How the Mail Order Service Works:**

- New prescriptions must be mailed to Express Scripts by your provider, faxed to 1.888.327.9791, or you can mail in your prescription with a completed order form found at [www.premera.com](http://www.premera.com). Ask your provider to write two prescriptions – one for 30 days that you can fill quickly at a local Express Scripts retail pharmacy and one for 90 days that you can mail to Express Scripts.
- Refill prescriptions can then be ordered easily online once you’ve set up your prescriptions. You can also call Express Scripts at 1.800.391.9701.
- Mail order delivery can take up to two weeks, so be sure to have enough medication on hand.

**Out-of-Area Benefits**

If you are traveling or living outside of Washington and need medical care, you may use a Blue Cross or Blue Shield PPO provider to receive the same benefits as the preferred level of your plan. When you are outside of the service area and need medical care, call the Blue Card Access Line at 800.810-BLUE (2583) for information on the nearest PPO doctors and hospitals. The doctor or hospital will verify your membership and coverage information after you present your identification/membership card. The doctor or hospital will electronically route your claim to your Blue Cross plan for processing. Because all PPO providers are paid by the plan directly, you are not required to pay for the care at time of service and then wait for reimbursement. You will only need to pay for out-of-pocket expenses, such as non-covered services, deductible, copays and coinsurance.

**2014 DENTAL BENEFITS (PREMERA OPTIMA)**

Premera Optima allows you to obtain care from participating or non-participating dentists. The choice is yours any time you need dental care. However, 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 billed amount 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.

You may enroll in the dental plan even if you do not enroll in a medical plan. You may decide not to enroll in the dental plan, whether or not you have other dental coverage, unlike the medical plan.

You make pretax payroll deductions to purchase dental coverage for you, your spouse and/or your dependent children. Your domestic partner (DP) and/or the child or your DP are also eligible for coverage under the dental plan. You pay the total premium for your DP’s and/or the children of your DP on an after-tax basis.

<table>
<thead>
<tr>
<th>Coverage Categories</th>
<th>Premium Total and Faculty/Staff Share*</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>$ 53</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
<td>$105</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
<td>$120</td>
</tr>
<tr>
<td>You, Spouse/Partner &amp; Child(ren)</td>
<td>$172</td>
</tr>
</tbody>
</table>

*Semi-monthly payroll deductions will be equivalent to half of the premium listed.

**Covered Dental Services**

Dental services include a $50 annual deductible per participant ($150 maximum per family) and coinsurance on basic and 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 100 percent (not subject to annual deductible):
- Oral exams (two per calendar year)
- Topical fluoride application for children under the age of 20 (two per calendar year)
- Prophylaxis (two per calendar year)
- Dental x-rays
- 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 then covered at 80 percent:
- Emergency palliative treatment
- Simple fillings
- Extractions
- Endodontics (root canals)
- Oral surgery
- Periodontics

**Major Services** are subject to the annual deductible then covered at 50 percent:
- Repair of crowns, 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 $1,500 per participant. Orthodontia benefits are covered at 100 percent of the allowable charges up to a lifetime maximum of $1,000 per participant.

2014 GROUP LIFE AND AD&D INSURANCE (UNUM LIFE INSURANCE COMPANY)

The university provides you with $25,000 group life insurance coverage and $25,000 basic accidental death and dismemberment (AD&D) insurance coverage, both at no cost to you. AD&D insurance provides benefits to your beneficiary in the event of your accidental death or to you in the event of accidental dismemberment (loss of limbs, sight, hearing, etc.). For example, if you were to die in an accident, your beneficiary would receive a minimum of $50,000 -- $25,000 in the form of the basic life insurance benefit (more if you purchase additional coverage) and $25,000 in the form of the basic AD&D benefit (more if you purchase additional coverage).
Voluntary Life Insurance

Each year you can increase your voluntary life coverage by one level until you reach the maximum voluntary life insurance benefit of $175,000. You can purchase additional voluntary life insurance protection as noted below.

### Table 6 – Unum Voluntary Life Insurance – Monthly Premiums*

<table>
<thead>
<tr>
<th>Age as of 1/1/2014</th>
<th>Option I $10,000</th>
<th>Option II $25,000</th>
<th>Option III $50,000</th>
<th>Option IV $100,000</th>
<th>Option V $150,000</th>
<th>Option VI $175,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.40</td>
<td>$1.00</td>
<td>$2.00</td>
<td>$4.00</td>
<td>$6.00</td>
<td>$7.00</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.40</td>
<td>$1.00</td>
<td>$2.00</td>
<td>$4.00</td>
<td>$6.00</td>
<td>$7.00</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.60</td>
<td>$1.50</td>
<td>$3.00</td>
<td>$6.00</td>
<td>$9.00</td>
<td>$10.50</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.80</td>
<td>$2.00</td>
<td>$4.00</td>
<td>$8.00</td>
<td>$12.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>40-44</td>
<td>$1.00</td>
<td>$2.50</td>
<td>$5.00</td>
<td>$10.00</td>
<td>$15.00</td>
<td>$17.50</td>
</tr>
<tr>
<td>45-49</td>
<td>$1.60</td>
<td>$4.00</td>
<td>$8.00</td>
<td>$16.00</td>
<td>$24.00</td>
<td>$28.00</td>
</tr>
<tr>
<td>50-54</td>
<td>$2.20</td>
<td>$5.50</td>
<td>$11.00</td>
<td>$22.00</td>
<td>$33.00</td>
<td>$38.50</td>
</tr>
<tr>
<td>55-59</td>
<td>$4.20</td>
<td>$10.50</td>
<td>$21.00</td>
<td>$42.00</td>
<td>$63.00</td>
<td>$73.50</td>
</tr>
<tr>
<td>60-64</td>
<td>$6.60</td>
<td>$16.50</td>
<td>$33.00</td>
<td>$66.00</td>
<td>$99.00</td>
<td>$115.50</td>
</tr>
<tr>
<td>65-69</td>
<td>$12.80</td>
<td>$32.00</td>
<td>$64.00</td>
<td>$128.00</td>
<td>$192.00</td>
<td>$224.00</td>
</tr>
<tr>
<td>70 and over</td>
<td>$20.60</td>
<td>$51.50</td>
<td>$103.00</td>
<td>$206.00</td>
<td>$309.00</td>
<td>$360.50</td>
</tr>
</tbody>
</table>

* Semi-monthly payroll deductions will be equivalent to half of the premium listed.

If you elect voluntary life insurance above $25,000 (Options III - VI) 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 Form W-2 at the end of the year.

Voluntary Accidental Death & Dismemberment Insurance

You can purchase additional AD&D insurance for yourself, your spouse/partner and your dependent child(ren). You must purchase AD&D coverage for yourself in order to purchase AD&D coverage for your spouse, partner and/or dependent child(ren). Evidence of insurability is not required for any amount of voluntary AD&D coverage. The design is as follows:

- **Your own coverage** may be purchased in increments of $10,000, up to a maximum benefit of $300,000.
- **Spouse/partner coverage** may be purchased in increments of $10,000, up to $300,000 (not to exceed the amount of your own election). Domestic partner premiums are paid on an after-tax basis.
- **Dependent child(ren) coverage** may be purchased in increments of $10,000, up to $20,000 (not to exceed the amount of your own election). Premiums for the child of a domestic partner are paid on an after-tax basis.

The table below contains the monthly premiums for the additional AD&D insurance available through Unum.

### Table 7 – Voluntary AD&D Insurance Monthly Premiums by Coverage Category*

<table>
<thead>
<tr>
<th>AD&amp;D</th>
<th>You</th>
<th>Spouse/Partner</th>
<th>Child(ren)</th>
<th>AD&amp;D</th>
<th>You</th>
<th>Spouse/Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$0.26</td>
<td>$0.26</td>
<td>$0.26</td>
<td>$160,000</td>
<td>$4.16</td>
<td>$4.16</td>
</tr>
<tr>
<td>$20,000</td>
<td>$0.52</td>
<td>$0.52</td>
<td>$0.52</td>
<td>$170,000</td>
<td>$4.42</td>
<td>$4.42</td>
</tr>
<tr>
<td>$30,000</td>
<td>$0.78</td>
<td>$0.78</td>
<td>n/a</td>
<td>$180,000</td>
<td>$4.68</td>
<td>$4.68</td>
</tr>
<tr>
<td>$40,000</td>
<td>$1.04</td>
<td>$1.04</td>
<td>n/a</td>
<td>$190,000</td>
<td>$4.94</td>
<td>$4.94</td>
</tr>
<tr>
<td>$50,000</td>
<td>$1.30</td>
<td>$1.30</td>
<td>n/a</td>
<td>$200,000</td>
<td>$5.20</td>
<td>$5.20</td>
</tr>
<tr>
<td>$60,000</td>
<td>$1.56</td>
<td>$1.56</td>
<td>n/a</td>
<td>$210,000</td>
<td>$5.46</td>
<td>$5.46</td>
</tr>
<tr>
<td>$70,000</td>
<td>$1.82</td>
<td>$1.82</td>
<td>n/a</td>
<td>$220,000</td>
<td>$5.72</td>
<td>$5.72</td>
</tr>
<tr>
<td>$80,000</td>
<td>$2.08</td>
<td>$2.08</td>
<td>n/a</td>
<td>$230,000</td>
<td>$5.98</td>
<td>$5.98</td>
</tr>
<tr>
<td>$90,000</td>
<td>$2.34</td>
<td>$2.34</td>
<td>n/a</td>
<td>$240,000</td>
<td>$6.24</td>
<td>$6.24</td>
</tr>
<tr>
<td>$100,000</td>
<td>$2.60</td>
<td>$2.60</td>
<td>n/a</td>
<td>$250,000</td>
<td>$6.50</td>
<td>$6.50</td>
</tr>
<tr>
<td>$110,000</td>
<td>$2.86</td>
<td>$2.86</td>
<td>n/a</td>
<td>$260,000</td>
<td>$6.76</td>
<td>$6.76</td>
</tr>
<tr>
<td>$120,000</td>
<td>$3.12</td>
<td>$3.12</td>
<td>n/a</td>
<td>$270,000</td>
<td>$7.02</td>
<td>$7.02</td>
</tr>
<tr>
<td>$130,000</td>
<td>$3.38</td>
<td>$3.38</td>
<td>n/a</td>
<td>$280,000</td>
<td>$7.28</td>
<td>$7.28</td>
</tr>
<tr>
<td>$140,000</td>
<td>$3.64</td>
<td>$3.64</td>
<td>n/a</td>
<td>$290,000</td>
<td>$7.54</td>
<td>$7.54</td>
</tr>
<tr>
<td>$150,000</td>
<td>$3.90</td>
<td>$3.90</td>
<td>n/a</td>
<td>$300,000</td>
<td>$7.80</td>
<td>$7.80</td>
</tr>
</tbody>
</table>

* Semi-monthly payroll deductions will be equivalent to half of the premium listed.
The university offers voluntary group short-term disability insurance through Unum Life Insurance Company. This insurance coverage pays a percentage of gross weekly salary if the insured faculty or staff member cannot work due to pregnancy disability or a covered injury or illness. These income benefits can provide added financial security during such times.

If a faculty or staff member becomes temporarily or permanently disabled due to a serious injury or illness, there is a window of up to six months of qualifying disability before university-paid long-term disability payments begin. As you make a decision about participating in this voluntary short-term disability program, we hope that you carefully consider how an extended period of income loss could affect you and your family.

Please note: In order to offer the voluntary group short-term disability policy described below, Puget Sound must maintain a minimum participation rate of 25 percent of those eligible for this benefit. If 25 percent of those eligible to enroll do not participate, Unum may not provide this benefit.

Following is a description of your short-term disability benefits:

- The benefit is equal to 60 percent of your salary, up to a maximum of $2,000 per week.
- Premiums for this coverage are paid on an after-tax basis, which means that the actual benefit, when received, will not be taxable, maximizing your benefit payment. Additionally, you are allowed to drop the benefit at any time, effective the first of the month following Human Resources’ written receipt of your request.
- There is a 14-day waiting period from the onset of the illness/injury and when benefits begin (should you become disabled, you would use university-provided paid leave benefits or, if you have no paid leave benefits, be on leave without pay during the 14-day waiting period).
- There is a maximum benefit period of 24 weeks, which dovetails with the university-paid long-term disability benefits (for those working 0.75 FTE or greater). Together, these two benefits provide little to no break in income protection under covered circumstances. Note, however, that there is generally a one-year waiting period for eligibility for university-paid LTD benefits, so an individual would generally have to be employed in an eligible position for one year to be covered by the LTD policy and then experience six months of qualifying disability before actually qualifying for any LTD payments (eligibility for benefit payments is determined by Unum Life Insurance Company).
- If you enroll during your initial period of eligibility for this benefit (within 30 days of hire or change to a benefits-eligible position), you do not need to provide evidence of insurability to qualify for coverage.
- Enrollment in this plan during any open enrollment period following your initial offer to elect this benefit is subject to evidence of insurability before you qualify for coverage. You may obtain an Evidence of Insurability Form from Human Resources. Human Resources must receive Unum’s approval of your Evidence of Insurability with an approval date of no later than December 31, 2013, in order to enroll you on short-term disability benefits in 2014. You will not be enrolled on 2014 short-term disability benefits if your Unum approval date is after December 31, 2013, so please take action early to ensure that Unum has enough time to process your application.
- If you receive medical treatment, consultation, care or services (including diagnostic measures and medications) during the three month period immediately preceding enrollment on the plan, there will be a 12-month pre-existing condition waiting period on that condition, and that condition won’t qualify you for benefits until the 12-month pre-existing condition exclusion period has elapsed.
- Should you qualify for short-term disability benefits, you would receive the benefits from Unum in addition to your university-provided paid leave benefits (faculty disability salary continuance benefits; staff sick leave and vacation leave benefits). This could provide you with additional income to help pay medical bills and other expenses during your period of disability.
- In addition to providing benefits in the event of temporary and permanent physical disabilities, this policy
also provides benefits for disabilities related to mental health conditions.

Because the short-term disability benefits being offered are priced at a group rate, the premiums are generally much more affordable than individual plans that may be available on the "open market." Premiums for short-term disability benefits are paid through payroll deductions, based on the rates below.

<table>
<thead>
<tr>
<th>Age as of 1/1/2014</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>$0.54</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.60</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.52</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.42</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.40</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.42</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.50</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.68</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.86</td>
</tr>
<tr>
<td>65+</td>
<td>$0.98</td>
</tr>
</tbody>
</table>

The following provides a general breakdown of monthly costs based on age and annual salary. Semi-monthly payroll deduction will be equivalent to half of the premium listed.

<table>
<thead>
<tr>
<th>Age as of 1/1/2014</th>
<th>$20,000</th>
<th>$40,000</th>
<th>$60,000</th>
<th>$80,000</th>
<th>$100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>$12.46</td>
<td>$24.92</td>
<td>$37.38</td>
<td>$49.85</td>
<td>$62.31</td>
</tr>
<tr>
<td>25-29</td>
<td>$13.85</td>
<td>$27.69</td>
<td>$41.54</td>
<td>$55.38</td>
<td>$69.23</td>
</tr>
<tr>
<td>30-34</td>
<td>$12.00</td>
<td>$24.00</td>
<td>$36.00</td>
<td>$48.00</td>
<td>$60.00</td>
</tr>
<tr>
<td>35-39</td>
<td>$ 9.69</td>
<td>$19.38</td>
<td>$29.08</td>
<td>$38.77</td>
<td>$48.46</td>
</tr>
<tr>
<td>40-44</td>
<td>$ 9.23</td>
<td>$18.46</td>
<td>$27.69</td>
<td>$36.92</td>
<td>$46.15</td>
</tr>
<tr>
<td>45-49</td>
<td>$ 9.69</td>
<td>$19.38</td>
<td>$29.08</td>
<td>$38.77</td>
<td>$48.46</td>
</tr>
<tr>
<td>50-54</td>
<td>$11.54</td>
<td>$23.08</td>
<td>$34.62</td>
<td>$46.15</td>
<td>$57.69</td>
</tr>
<tr>
<td>55-59</td>
<td>$15.69</td>
<td>$31.38</td>
<td>$47.08</td>
<td>$62.77</td>
<td>$78.46</td>
</tr>
<tr>
<td>60-64</td>
<td>$19.85</td>
<td>$39.69</td>
<td>$59.54</td>
<td>$79.38</td>
<td>$99.23</td>
</tr>
<tr>
<td>65+</td>
<td>$22.62</td>
<td>$45.23</td>
<td>$67.85</td>
<td>$90.46</td>
<td>$113.08</td>
</tr>
</tbody>
</table>

Example of faculty/staff member age 30 earning $30,000 per year:

<table>
<thead>
<tr>
<th>Annual Salary</th>
<th>$30,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divide by Weeks</td>
<td>÷ 52</td>
</tr>
<tr>
<td>Weekly Benefit Percent</td>
<td>x 60%</td>
</tr>
<tr>
<td>Weekly Benefit</td>
<td>$346.15</td>
</tr>
<tr>
<td>To Find Rate Per $10 of Benefit</td>
<td>÷ $10</td>
</tr>
<tr>
<td>Rate by Age (see Table 8)</td>
<td>x $0.52</td>
</tr>
<tr>
<td>Monthly Cost</td>
<td>$18.00</td>
</tr>
<tr>
<td>Semi-Monthly Payroll Deduction</td>
<td>$9.00</td>
</tr>
</tbody>
</table>
2014 FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Accounts are administered by ConnectYourCare in partnership with our medical vendor, Premera Blue Cross. You may submit claims, view your balances, and check the status of claim submissions by logging into a single site: www.premera.com.

How to Use an FSA
Using a Flexible Spending Account (FSA) is a three-step process:

Step 1: Estimate the amount of eligible health care expenses and eligible dependent care expenses you expect to incur during the 2014 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 FSA (up to $2,500 annually) for eligible health care expenses and/or to a Dependent Care FSA (up to $5,000 annually) for eligible dependent care expenses. You will make your contributions to your FSA(s) through pretax payroll deductions.

The advantage of a flexible spending account is that funds placed into an FSA reduce the taxable income on your paychecks for the year. When funds from your FSA are paid out to reimburse eligible expenses, they are not considered to be taxable income. Therefore, you use pretax salary dollars to pay expenses you would otherwise be paying with after-tax income and you pay less in income taxes.

Money deposited in a flexible spending account may be paid out only to reimburse eligible expenses incurred between your effective date of enrollment and December 31, 2014. (Different date restrictions will apply when a faculty or staff member's employment ends before December 31, 2014. See page 18, When Flexible Spending Account(s) Participation Ends, for more information.) If money is left over in an account after these dates, it must be forfeited. So, if you use a spending account, you should estimate carefully what your eligible expenses will be.

For Health Care FSA contributions made in 2013, you will have through March 15, 2014, to incur expenses eligible for reimbursement from your 2013 Health Care FSA.

Step 2: Keep track of your eligible health care and/or dependent care expenses and keep all related receipts.

Step 3: From time to time during the year, you submit a claim and receive reimbursement from your FSA with tax-free dollars.

  o In the Health Care FSA, you may file a claim up to the total annual amount you have elected to deposit, even if the full amount has not yet been withheld from your paychecks. 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.

  o In the Dependent Care FSA, you may file a claim only for what has already been withheld from your paychecks when you submit the claim.

  o If you are seeking reimbursement during your very first month of enrollment in this program, please anticipate a potential delay in the processing of your claim, as the administrator may be waiting for the university to submit your enrollment information.

Deposits to an FSA
On your Election and Enrollment/Re-Enrollment Form, you need to indicate how much money, if any, you want to deposit in each of your two FSAs.

  • The Health Care FSA allows a maximum annual election of $2,500 in 2014 (no more than $208.34 per month).

  • The Dependent Care FSA allows a maximum annual election of $5,000 (no more than $416.67 per month). You may not be able to deposit the maximum available under this flexible spending account if any of these situations applies to you:

    o If you are married but file a separate tax return, you may deposit a maximum of $2,500 in the Dependent Care FSA.
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 dependents.

You may not increase, reduce, or stop your FSA deposits during the year unless you have a qualifying family status change. For more information, see the section called Making Election Changes in the Future. Balances in spending accounts do not earn interest.

**Filing FSA Claims**

Under both accounts, claims are submitted to ConnectYourCare. If you have questions about your claims, please call 1.800.941.6121. When you enroll in a flexible spending account, ConnectYourCare will mail to your home address claim forms and full instructions about the program, including how to submit claims, how to access your account through your medical plan on the Premera website, and how to have your reimbursements directly deposited to your bank account.

You will need to submit all 2014 claims to ConnectYourCare no later than March 31, 2015, in order to be reimbursed for eligible expenses. (Different deadlines may apply when a faculty or staff member’s employment ends before December 31, 2014. For more information, see the section called When Flexible Spending Account(s) Participation Ends.)

The university is not responsible for the postage to mail your claims to ConnectYourCare. 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 envelopes 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 FSA. Certain child care expenses for your dependents can be reimbursed from your Dependent Care FSA. You cannot “cross over” from one account to the other; expenses can be reimbursed only from the proper account. Below are some general rules about eligible and ineligible expenses under each plan. For more information about eligible expenses and non-eligible expenses, see IRS Publications 502 (Medical and Dental Expenses) and 503 (Child and Dependent Care Expenses) available from a public library, local IRS office or the IRS website (www.irs.gov).
<table>
<thead>
<tr>
<th>Eligible Expenses</th>
<th>Both FSA Plans</th>
<th>Health Care FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenses must meet Internal Revenue Service (IRS) requirements as described in IRS Code.</td>
<td>Eligible care expenses (further summarized below) incurred by you, your spouse, and your dependent children</td>
<td>Designed to reimburse you for child care 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.</td>
<td></td>
</tr>
<tr>
<td>2014 expenses must be incurred between your effective date of enrollment and December 31, 2014.</td>
<td>Medical deductibles, coinsurance, and copayments (the portion of medical charges you pay)</td>
<td>Charges for the care of your children (age 12 and under) or a person of any age who is unable to care for themselves because of physical or mental disability, whom you are able to claim as a dependent on your federal income tax return</td>
<td></td>
</tr>
<tr>
<td>(Different deadlines may apply when a faculty or staff member’s employment ends before December 31, 2014. For more information, see When Flexible Spending Account(s) Participation Ends.)</td>
<td>Most medical expenses not covered by a medical plan, such as hearing aids, glasses, contact lenses, and prescribed over-the-counter drugs</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>You can submit claims until March 31, 2015.</td>
<td>Dental deductibles and copayments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Most dental expenses not covered by a dental plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ineligible Expenses</td>
<td>Expenses incurred after December 31, 2014 (Different deadlines may apply when a faculty or staff member’s employment ends before December 31, 2014. For more information, see When Flexible Spending Account(s) Participation Ends.)</td>
<td>Over-the-counter (OTC) medicines and drugs (such as Advil, Tylenol, allergy medicine, antacid, etc.) unless you have a prescription from a licensed health care professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You cannot claim the same expenses on your tax return at the end of the year</td>
<td>Cosmetic surgery, unless required to treat an illness, injury, or deformity arising from a congenital abnormality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Funeral and burial expenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Household and domestic help</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Custodial care in an institution</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health club dues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expenses already reimbursed by the HRA (if enrolled in the high-deductible HRA plan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Premiums for other health care plans (such as your spouse’s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any expense for which you have or will receive reimbursement from any other source, such as through your spouse’s or partner’s health plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Additional Notes about Dependent Care Expenses
You will have to provide your care provider’s name, address, and Social Security number (or other taxpayer identification number) 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 FSA 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 FSA.

When Flexible Spending Account(s) Participation Ends
Your participation in the spending accounts will end on the earliest of:

- The date you are no longer employed by the university (including retirement)
- The date the spending accounts are terminated by the university
- The date you are no longer eligible for participation in the FSA

When any of the above events occurs, all pretax contributions to your flexible spending account will end.

For the Health Care FSA, claims for expenses incurred before your termination date must be submitted to ConnectYourCare by March 31, 2015. Expenses incurred after your termination date will not be eligible for reimbursement unless you elect to continue your Health Care FSA contributions for a certain period on an after-tax basis under the terms of COBRA. See page 21, Continued Benefits Coverage under COBRA, for more information.

For the Dependent Care FSA, you may submit claims for expenses incurred through December 31, 2014, including claims incurred after your termination date. All claims must be submitted to ConnectYourCare by March 31, 2015.

Leaves of Absence
Your FSA participation may be affected if you are on a leave of absence. The effects on your participation depend on the type of leave you take.

Family and Medical Leave: If you take a paid leave of absence under the provisions of the Family and Medical Leave Act of 1993 (FMLA), your FSA contributions will continue during your leave, unless you choose to discontinue your Health Care FSA contributions. If you take an unpaid FMLA leave, your FSA contributions may be suspended during the time you are on leave. You may begin contributions when you return to work. You may continue to file claims for eligible expenses during the time you are on leave.

Other Leaves of Absence: If you are on a paid leave of absence, your FSA 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 FSA participation continues during the time that you are on leave only if you make the required contributions on an after-tax basis.

If You Die While Participating
If you die while participating in the flexible spending 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 FSA ends because you no longer work for the university or you died, you or your dependents may be able to elect continuation of the Health Care FSA coverage for the rest of the year by making after-tax contributions. See page 21, Continued Benefits Coverage under COBRA, for more information.

Your Dependent Care FSA participation may not be continued under COBRA.

Flexible Spending Account Decisions for 2014
Should you deposit money to one or both Flexible Spending Accounts? Here are some questions to ask yourself before you decide:

1. Do I plan to incur expenses that would be eligible for reimbursement (such as eligible health care expenses and/or child care expenses)?
2. Can I make a fairly accurate prediction of the eligible health care and/or dependent care expenses my family will incur, so I avoid any forfeitures?
3. How much can I afford to contribute each month without affecting my ability to meet day-to-day expenses?

### THE NEXT STEPS FOR YOUR ENROLLMENT

Complete the following forms:

- 2014 Benefits Election and Enrollment Form *(required if you are newly-eligible for benefits or are making changes to 2014 benefit elections)*
- Unum Evidence of Insurability Form *(required if you want to apply for short-term disability benefits after your initial opportunity to purchase such benefits)*
- Affidavit of Marriage or Domestic Partnership Form *(required if you are enrolling your spouse, domestic partner, or the child of a domestic partner for a benefit for the first time)*
- Unum Beneficiary Designation Form for Group Life and Group Accident Insurance *(optional but highly suggested)*

**NEWLY ELIGIBLE:** If you are newly eligible for flexible benefits, you have 30 days from your date of hire (or appointment to a benefits-eligible position) to select benefits. If you do not turn in these forms within 30 days of your date of hire or eligibility, your 2014 enrollment will automatically default to the High Deductible HRA medical plan for yourself only.

After your election period is over, you will not have the opportunity to make changes to your benefits until next year’s open enrollment, unless you experience a qualifying status change during the year. Refer to pages 19-20 for more details about qualifying status changes.

### MAKING ELECTION 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 eligible to enroll in a university-sponsored medical or dental plan under the special enrollment period rules.

Coverage must begin the first of the month coinciding with or following the date of the qualifying event.

**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 university 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.
- You or your dependents lose health coverage under Medicaid or your state Children’s Health Insurance Program (CHIP).
- You become eligible for state premium assistance for purchasing coverage under a group health plan (does not include ACA-sponsored health benefit exchange plans).

Special enrollment is **not permitted** due to enrollment or un-enrollment in 1) an ACA-sponsored health benefit exchange plan or 2) another plan due to the annual open enrollment period of the other plan.
The following will disqualify you for special enrollment:

- Coverage is lost due to failure to pay premiums or for cause.
- After termination of other coverage, you and/or your dependents do not request special enrollment within the required time frame listed under the Status Change section.

Special enrollment for new dependents
The plan offers a special enrollment period for certain new dependents. A new dependent due to marriage or establishment of the domestic partnership, birth, adoption, or placement for adoption triggers a special enrollment period for each new dependent and your spouse/partner, if your spouse/partner is eligible but not enrolled in the plan. The following rules must be met in order to qualify for special enrollment:

- Special enrollment request must be made within the required time frame under the Status Change section.
- You, your spouse/partner and/or your new dependent must be allowed to enroll during the special enrollment period.
- In the case of a dependent acquired through marriage or establishment of the domestic partnership, coverage must begin the first of the month coinciding with or following the date of the qualifying event.
- In the case of birth, adoption or placement for adoption, coverage begins on the date the event occurred. In the case of birth, premiums are charged as described on the Election and Enrollment Form.

Status Change
If one or more of the following changes in status occurs, you may revoke your old election during the year and make a new election, provided that both the revocation and new election are on account of and correspond with the change in status, and you have notified Human Resources within the time frame listed next to that item.

- Change in your legal marital status or domestic partnership, including death of your spouse/partner (within 30 days of event)
- Change in the number of your dependents, other than a newborn or an adopted newborn child (within 30 days of event)
  - In the case of death, the full premium is charged for the month in which the death occurs
- Newborn or an adopted newborn child (within 60 days of event)
  - In the case of birth, premiums are charged as described on the Election and Enrollment Form
  - Under the Erin Act newborns are automatically covered for the first 21 days of life
- Change in the employment status of you or your spouse/partner (within 30 days of event)
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (within 30 days of event)
- A change in your, your spouse’s/partner’s, or your child’s place of residence (within 30 days of event)
- Loss or gain of eligibility under another employer’s plan (within 30 days of event)
- Enrollment in or loss of Medicare coverage (within 30 days of event)
- Eligibility or loss of eligibility for Medicaid or CHIP coverage (within 60 days of event)

A qualified status change does not allow you to change from one medical plan to the other in the middle of a plan year.

CONTINUED BENEFITS COVERAGE UNDER COBRA

Introduction
This notice contains important information about your right to COBRA continuation coverage (“COBRA”), which is a temporary extension of coverage under the Plan. This notice generally explains COBRA, when it may become available to you and your family, and what you need to do to protect the right to receive it.
The right to COBRA was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

**What is COBRA?**

COBRA is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse’s hours of employment are reduced;
- your spouse’s employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The University of Puget Sound, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**When is COBRA available?**

The Plan will offer COBRA to qualified beneficiaries after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (Part A, B, or both), the employer must notify the Plan Administrator of the qualifying event.

**You must give notice of some qualifying events.**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: University of Puget Sound, Human Resources – Benefits, 1500 N Warner #1064, Tacoma, WA 98416-1064. You then have 45 days from the date you submit your application to make your first payment.

**How is COBRA provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children.
COBRA is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA can be extended.

Disability extension of 18-month period of coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA and must last at least until the end of the 18-month period of coverage.

Second qualifying event extension of 18-month period of coverage
If your family experiences another qualifying event while receiving 18 months of COBRA, the spouse and dependent children in your family can get up to 18 additional months of COBRA, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If you have questions
Questions about the Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more 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/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.

Keep your plan informed of address changes
In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Mailing: University of Puget Sound Human Resources – Benefits
1500 N Warner #1064,
Tacoma, WA, 98416-1064
Campus location: Howarth Hall #016
Phone: 253.879.3369
Fax: 253.879.2839
Email: hr@pugetsound.edu
Here is additional information about your benefits.

**Plan Sponsor and Plan Administrator:** University of Puget Sound is the employer whose eligible faculty and staff members are covered by the university Flexible Benefits Plan and also serves as the Plan Administrator. The university's address is 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 or emailing hr@pugetsound.edu.

**Employer Identification Number:** 91-0564961

**Plan Name:** University of Puget Sound Flexible Benefits Plan

**Plan Number:** 507

**Plan Type:** Welfare Benefit Plan

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

**Type of Administration:** Premera Blue Cross and Unum Life Insurance Company provide claims administration and other services for the medical insurance, health reimbursement arrangement (HRA), dental insurance, flexible spending accounts, life insurance, accidental death and dismemberment (AD&D) insurance, and disability insurance benefit plans.

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

**Source of Benefit Payments:** Medical, dental, life insurance, AD&D insurance, and disability benefits are paid by the carriers through insurance contracts. HRA, health care FSA and dependent care FSA 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 university Flexible Benefits Plan is Human Resources, University of Puget Sound, 1500 N. Warner St #1064, Tacoma, WA 98416-1064.

**Future of the Plans:** Changes to the Plan 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 election guide is a summary of some features of the Flexible Benefits Plan. Details on the medical, dental, life insurance, accidental death and dismemberment (AD&D) insurance, and disability benefits are provided in separate booklets. Those booklets, together with this election guide, constitute the summary plan description for the Flexible Benefits Plan. This election guide 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 election guide 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 Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the documents governing the plan, including the insurance contract and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

You have a right to continue healthcare 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.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

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 these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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, 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 your rights under ERISA, or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Mastectomy Benefits
The Women’s Health and Cancer Right Act of 1998 requires medical plans that offer mastectomy benefits to also provide coverage for reconstructive surgery benefits. Coverage extends to:

- Reconstructive surgery of the breast on which the mastectomy is performed;
- Treatment to produce a symmetrical appearance following a mastectomy; prostheses; and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

As with the other covered services provided under your medical plan, annual deductibles, copays, and coinsurance may apply to these mastectomy benefits.

Newborns’ Act
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).

Family and Medical Leave Act
Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the
Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days’ notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified.

Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights. FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. §
Important Information about Health Benefit Exchange Coverage Options

When key parts of the Patient Protection and Affordable Care Act (ACA) take effect in 2014, there will be a new way to buy health insurance. You will see these health care options referred to as the “health insurance marketplace,” the “health benefit exchange,” or simply “the exchange.” To assist you in evaluating options for you and your family, this notice provides some basic information about health care options available through the exchange.

1. What is the health benefit exchange and how does it work?
The health benefit exchange was established to increase access to affordable health care for individuals who may not normally qualify for health care benefits offered through employers.

Many states, including Washington, will offer their own health benefit exchange. Individuals in states not offering an exchange will have access to a health benefit exchange operated by the federal government. The exchange offers a single place to find and compare private health insurance options.

2. Can I save money on health insurance premiums in the exchange?
Possibly. There are many different levels of coverage offered through several different insurance companies at varying premium rates.

In addition, you might be eligible for a new tax credit that lowers your monthly premium, but only if you aren’t eligible for medical coverage through an employer or if the employer-provided coverage doesn’t meet certain affordability and coverage standards. (Both university-sponsored medical plans comply with all ACA-required changes. If you are enrolled in a university-sponsored medical plan, your health care coverage will exceed the ACA-mandated affordability and coverage requirements.)

3. Does the medical coverage offered by University of Puget Sound affect my eligibility for premium savings through the exchange?
Yes. If you are eligible for University of Puget Sound medical benefits and you choose to buy insurance through the exchange, Puget Sound will not provide funding to purchase the exchange insurance, but will continue to provide funding for your university-sponsored medical coverage. Because University of Puget Sound pays 100 percent of employee-only coverage on the high-deductible medical plan and the coverage meets ACA requirements, it is unlikely that coverage through the exchange will be an attractive option for your own coverage.

In addition, since University of Puget Sound offers medical coverage to spouses/partners and dependent children, and the university medical plans meet the ACA-mandated affordability and coverage requirements, you will not be eligible for a financial subsidy from the government to help pay for any coverage you may purchase through the exchange.

Should you choose to elect coverage through the exchange, your payments for such coverage will be made on an after-tax basis (as opposed to the pretax basis for which you pay for your own coverage on the university-sponsored low-deductible plan and for family members on either plan).

4. What if I’m not eligible for University of Puget Sound medical benefits?
Whether or not you are eligible to participate in the University of Puget Sound medical plan, you may choose to obtain medical coverage through the health benefit exchange. Depending on your household income, you may also be eligible for a tax credit and/or premium assistance to help reduce the cost of health coverage obtained.
through the exchange (but only if you are not eligible for university-sponsored medical benefits). The premium savings for which you may be eligible depends on your household income.

5. How can I sign up for coverage through the exchange?
Beginning October 1, 2013, you and your family members have the option to use an online marketplace to enroll for coverage that starts on January 1, 2014, or later.

- You can choose from four plan levels: Bronze, Silver, Gold and Platinum. One option isn’t necessarily better than the other. Each plan provides different levels of coverage to meet different needs.
- You can also choose from a variety of insurance companies. Each will offer its own price for each plan level. You can compare plans on the exchange website (www.wahbexchange.org) and see which option might be best for you.
- You can fill out an application on the Washington Health Exchange website to find out if you or your family members qualify for financial assistance in the form of premium discounts, subsidies for out-of-pocket expenses, or coverage under programs such as Medicare or Medicaid. Please keep in mind that these discounts and subsidies will not apply to you or your family members if you are eligible for coverage on a university-sponsored medical plan.

Information about health coverage offered by University of Puget Sound
This section contains information about health coverage offered by University of Puget Sound. If you decide to complete an application for coverage in the health benefit exchange, you will be asked to provide this information.

- **Employer Name:** The University of Puget Sound
- **Employer Identification Number (EIN):** 91-0564961
- **Employer Address:** 1500 N Warner St #1064, Tacoma, WA 98416-1064
- **Who can we contact about employee health coverage at this job?** Human Resources
- **Email address:** hr@pugetsound.edu
- **Eligible employees are:** Must be an active employee of the group who is paid on a regular basis through payroll, reported by the group for social security purposes and scheduled to work at least half-time appointment as defined in the group's plan document, or who is a full-time, one semester visiting faculty member, or be eligible for medical benefits as described by the early retirement policy.
- **With respect to dependents:** The spouse or domestic partner of the subscriber, unless legally separated. A spouse/domestic partner cannot enroll as both a spouse and a subscriber. A dependent child (natural, offspring or legally adopted or legally placed) who is under 26 years of age. Foster children aren't eligible for coverage.
- **Both University of Puget Sound medical plans meet the minimum coverage and affordability requirements as defined by the Affordable Care Act.**

6. Where can I go for more information about the exchanges?
Because the University of Puget Sound does not sponsor the plans offered in the new health benefit exchanges, Human Resources will not be able to answer questions or provide guidance regarding the exchange offerings. However, there are also several resources available to assist you with questions about the health benefit exchanges:

- **State of Washington exchange:** [www.wahbexchange.org](http://www.wahbexchange.org)
- **State of Washington health plan finder:** [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org) or 1.855.WAFINDER
- **Exchanges in other states (for those with dependents in other states):** [www.healthcare.gov](http://www.healthcare.gov)

For additional information on **Puget Sound’s 2014 health care plans**, please contact Human Resources at hr@pugetsound.edu, 253.879.3296, or Howarth 016 (M-F from 8 a.m. – noon, 1 – 5 p.m.)

**Medicare Part D Prescription Drug Notice from Premera**
This notice has information about your current prescription drug coverage with Premera Blue Cross and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions...
about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- Premera Blue Cross has determined that the prescription drug coverage offered by your health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When can you join a Medicare drug plan?**
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What happens to your current coverage if you decide to join a Medicare drug plan?**
If you decide to join a Medicare drug plan, your current Premera Blue Cross coverage will not be affected. You can keep your current coverage, but we will coordinate benefits with your Medicare Part D coverage so as not to duplicate payments. If your current coverage pays for other health expenses in addition to prescription drugs, you and your covered dependents will also still be eligible to keep your current health coverage. If you do decide to join a Medicare drug plan and drop your current Premera Blue Cross coverage, be aware that you and your dependents may not be able to get this coverage back.

**When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?**
You should also know that if you drop or lose your current coverage with Premera Blue Cross and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For more information about this notice or your current prescription drug coverage**
For further information, call Premera customer service at 1.800.722.9780. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Premera Blue Cross changes. You also may request a copy of this notice at any time.

**For more information about your options under Medicare prescription drug coverage**
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For more information about Medicare prescription drug coverage**
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may
be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Your University of Puget Sound prescription drug benefits are as follows:

<table>
<thead>
<tr>
<th>Date:</th>
<th>October 15, 2013</th>
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<tbody>
<tr>
<td>Name of Entity/Sender:</td>
<td>University of Puget Sound</td>
</tr>
<tr>
<td>Address:</td>
<td>1500 N. Warner St #1064, Tacoma, WA 98416-1064</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>253.879.3369</td>
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**Medicaid and CHIP Offer Free or Low-Cost Health Coverage to Children and Families**

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1.877.KIDSNOW (1.877.5437.669) or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1.866.444.EBSA (1.866.444.3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2013. You should contact your state for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid URL/Phone Information</th>
<th>State</th>
<th>Medicaid URL/Phone Information</th>
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<tr>
<td><em>ALABAMA</em></td>
<td>medicaid.alabama.gov or 1-855-692-5447</td>
<td><em>COLORADO</em></td>
<td>colorado.gov/Phone (In state): 1-800-866-3513</td>
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<tr>
<td>ALASKA</td>
<td>health.hss.state.ak.us/dpa/programs/medicaid/1-888-318-8890 or 907-269-6529</td>
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<td>Phone (Out of state): 1-800-221-3943</td>
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<tr>
<td><em>ARIZONA</em></td>
<td>azahcccs.gov/applicantsPhone (Outside Maricopa County): 1-877-764-5437Phone (Maricopa County): 602-417-5437</td>
<td><em>FLORIDA</em></td>
<td><a href="http://www.flmedicaidtplrecovery.com/Phone">www.flmedicaidtplrecovery.com/Phone</a>: 1-877-357-3268</td>
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<tr>
<td>IDAHO</td>
<td>accessstoehealthinsurance.idaho.gov or 1-800-926-2588medicaid.idaho.gov or 1-800-926-2588</td>
<td><em>GEORGIA</em></td>
<td>dch.georgia.gov/ or Phone: 1-800-869-1150</td>
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<tr>
<td>INDIANA</td>
<td>in.gov/fsaa or Phone: 1-800-889-9949</td>
<td><em>MONTANA</em></td>
<td>medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtmlPhone: 1-800-694-3084</td>
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<td><em>NEBRASKA</em></td>
<td><a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> or 1-800-383-4278</td>
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<td>STATE</td>
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<td>IOWA</td>
<td>Medicaid</td>
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<td>dhs.state.ia.us/hipp/ or 1-888-346-9562</td>
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<td>KANSAS</td>
<td>Medicaid</td>
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<td>kdheks.gov/hcf/ or Phone: 1-800-792-4884</td>
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<td>KENTUCKY</td>
<td>Medicaid</td>
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<td>chfs.ky.gov/dms/default.htm or 1-800-635-2570</td>
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<td>LOUISIANA</td>
<td>Medicaid</td>
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<tr>
<td>lhahipp.dhh.louisiana.gov or 1-888-695-2447</td>
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<tr>
<td>MAINE</td>
<td>Medicaid</td>
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<td>maine.gov/dhhs/olf/public-assistance/index.html</td>
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<tr>
<td>MICHIGAN</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>mass.gov/MassHealth</td>
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<tr>
<td>MINNESOTA</td>
<td>Medicaid</td>
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<tr>
<td>dhs.state.mn.us/ or 1-800-657-3629</td>
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<tr>
<td>MISSOURI</td>
<td>Medicaid</td>
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<td>dss.mo.gov/mhd/participants/pages/hipp.htm 573-751-2005</td>
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<tr>
<td>NEW HAMPSHIRE</td>
<td>Medicaid</td>
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<tr>
<td>dhhs.nh.gov/oii/documents/hippapp.pdf 603-271-5218</td>
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<tr>
<td>NEW JERSEY</td>
<td>Medicaid</td>
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<td>state.nj.us/humanservices/dmhs/clients/medicaid/</td>
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<tr>
<td>Phone: 609-631-2392</td>
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<td>NJ FAMILY CARE</td>
<td>Medicaid</td>
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<tr>
<td>njfamilycare.org/index.html</td>
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<tr>
<td>Phone: 1-800-701-0710</td>
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<tr>
<td>MASSACHUSETTS</td>
<td>Medicaid and CHIP</td>
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<td>mass.gov/MassHealth</td>
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<td>Phone: 1-800-462-1120</td>
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<td>dhs.state.mn.us/ or 1-800-657-3629</td>
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<td>dss.mo.gov/mhd/participants/pages/hipp.htm 573-751-2005</td>
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<td>NORTH CAROLINA</td>
<td>Medicaid</td>
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<td>ncdhhs.gov/dma or 919-855-4100</td>
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<td>NORTH DAKOTA</td>
<td>Medicaid</td>
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<td>nd.gov/dhs/services/medicalserv/medicaid/ 1-800-755-2604</td>
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<tr>
<td>OKLAHOMA</td>
<td>Medicaid and CHIP</td>
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<td>insureoklahoma.org or 1-888-365-3742</td>
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<tr>
<td>OREGON</td>
<td>Medicaid and CHIP</td>
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<td>oregonhealthykids.gov</td>
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<td>hjossaludablesoregon.gov</td>
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<td>Phone: 1-800-699-9075</td>
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<tr>
<td>PENNSYLVANIA</td>
<td>Medicaid</td>
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<td>dpw.state.pa.us/hipp or 1-800-692-7462</td>
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<td>RHODE ISLAND</td>
<td>Medicaid</td>
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<td><a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> or 401-462-5300</td>
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<td>WASHINGTON</td>
<td>Medicaid</td>
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<td>hyra.dshs.wa.gov/premiumpymt/Apply.shtm 1-800-562-3022 extension 15473</td>
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<td>SOUTH DAKOTA</td>
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<td>scdhhs.gov or 1-888-549-0820</td>
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<td>SOUTH CAROLINA</td>
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<td>WISCONSIN</td>
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<td>dss.sd.gov 1-888-828-0059</td>
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<td>TEXAS</td>
<td>Medicaid</td>
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<td>gethipptexas.com/ 1-800-440-0493</td>
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<td>WYOMING</td>
<td>Medicaid</td>
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<td>health.wyo.gov/healthcarefin/equalitycare 307-777-7531</td>
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To see if any more states have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1.866.444.EBSA (1.866.444.3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, menu option 4, extension 61565
HIPAA NOTICE OF PRIVACY PRACTICES

This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Health Information Privacy
This Notice is required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and is intended to describe how the University of Puget Sound health plan will protect your health information with respect to its self-insured health benefits. References below to Health Plan shall mean the medical, dental and health flexible spending account benefits provided by the Health Plan.

“Health information” for this purpose means information that identifies you and either relates to your physical or mental health condition, or relates to the payment of your health care expenses. This individually identifiable health information is known as “protected health information” (“PHI”). Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws.

Health Plan Privacy Obligations
The Health Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this Notice of its legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that are in effect

How the Health Plan May Use and Disclose Health Information about You
The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at
records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**SPECIAL SITUATIONS:**

**As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Workers’ Compensation.** We may release Health Information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person’s agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of
death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**USES/DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT**

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Uses and disclosures of Protected Health Information for marketing purposes; and

-Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

**YOUR RIGHTS**

You have the following rights regarding Health Information we have about you:

- **Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Human Resources. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the
form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Human Resources.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Human Resources.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Human Resources. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request in writing to Human Resources. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**CHANGES TO THIS NOTICE**
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS**
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Human Resources, University of Puget Sound, 1500 N Warner St #1064, Tacoma, WA 98416-1064 (phone 253.879.3369). All complaints must be made in writing. You will not be penalized for filing a complaint.

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all PHI that the Plans maintain, including information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.
IMPORTANT CONTACT INFORMATION

**Assist America** (travel assistance program)
Website: medservices@assistamerica.com
Phone: 1.800.872.1414 [within the U.S.]
(U.S. access code) 609.986.1234 [outside the U.S.]

**Express Scripts** (prescription drug benefits)
Phone: 1.800.391.9701
Fax: 1.888.327.9791

**Washington Health Benefit Exchange** (health plans resulting from the Affordable Care Act)
Website: www.wahbexchange.org
Phone: 1.855.WAFINDER (923.4633)

**Human Resources**
Email: hr@pugetsound.edu
Phone: 253.879.3369
Fax: 253.879.2839
Location: Howarth Hall 016 (Monday-Friday 8 a.m. to noon, 1 – 5 p.m.)

**Premera** (medical insurance, dental insurance, FSA and HRA questions)
Website: www.premera.com
Phone: 1.800.722.9780 [customer service]
1.800.810.BLUE (2583) [out-of-state Blue Card access line]

**TIAA-CREF** (retirement savings plan)
Website: http://www1.tiaa-cref.org/tcm/pugetsound/
Phone: 1.800.842.2252

**UNUM Life Balance** (employee assistance program)
Website: www.lifebalance.net [user ID and password is “lifebalance”]
Phone: 1.800.854.1446 [English]
1.877.858.2147 [Spanish]