This guide briefly summarizes the benefit 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
INSTRUCTIONS FOR ANNUAL OPEN ENROLLMENT
ACTIONS REQUIRED BY NOVEMBER 21, 2014

If you are a faculty or staff member who is currently eligible for 2014 flexible benefits, benefit changes for 2015 are allowed during the open enrollment period (November 3-21, 2014).

1. Review your 2014 benefit elections on the personalized Re-Enrollment Form that accompanied this election guide, or review your 2014 elections in PeopleSoft HR by following these steps:
   - Go to https://cascade.pugetsound.edu/
   - Log in to Cascade using your username and password (if you need help with your username or password, please contact the Technology Services Help Desk at extension 8585)
   - Select PeopleSoft Human Resources
   - Log in to PeopleSoft HR using your username and password
   - Select Main Menu, then Self Service, then Benefits, then Benefits Summary

2. 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 2015.

3. If you simply want to keep your current 2014 benefit elections, choose the “Re-enrollment Option” on the personalized Re-Enrollment Form that was delivered to your campus mailbox along with this Election Guide. Note that even if you choose to carry forward a majority of your 2014 benefit elections into 2015, the IRS requires you to actively elect participation in a Health Care Flexible Spending Account (“FSA”) and/or Dependent Care FSA each year, should you choose to do so. Your voluntary 2015 FSA election can also be made on the Re-Enrollment Form.

4. If you want to make changes to one or more benefit elections (medical insurance, voluntary dental insurance, voluntary life insurance, voluntary AD&D insurance, and/or voluntary short-term disability insurance) in 2015, including adding, removing, or modifying coverage for yourself or one of your family members, you are required to complete a new 2015 Benefits Election and Enrollment Form in its entirety. This form can be found on the HR website (www.pugetsound.edu/about/offices-services/human-resources/benefits/2015-flexible-benefits/).

5. Submit your Re-Enrollment Form OR your 2015 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) by November 21, 2014. 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 by November 21, 2014, your enrollment will automatically default to your current 2014 benefit and dependent enrollment elections but with no Flexible Spending Account (FSA) elections. 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 the section called Making Election Changes in the Future 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 5 p.m. during open enrollment). Computers and HR staff assistance will also be available on Wednesday, November 5, from 8:30 a.m. to 11:30 a.m., in the WSC Rotunda.
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 2015.

2. Complete your 2015 Benefits Election and Enrollment Form. Make sure to sign in all applicable signature locations.

3. Submit your 2015 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 the section called Making Election Changes in the Future 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.).
# 2015 Flexible Benefits Plan Election Guide

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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 family members 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, foster child, 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 26 if you request continued coverage for the child within 31 days of the child’s 26th birthday and provide documentation of disability.
- A foster child is further defined as a legally placed ward or foster child of the subscriber or spouse. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
- 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.

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:

\[
\text{Adjusted premium per month} = \frac{\text{Standard monthly premium} \times 12}{9} = \text{Standard monthly premium per month}
\]
An example using a benefit with a standard monthly premium of $36:

\[
\text{\$36 x 12 = \$432 annual premium} \div 9 \text{ months} = \$48 \text{ per month during the academic year}
\]

2015 MEDICAL BENEFITS (PREMERA BLUE CROSS)

In 2015, 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. 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% of the premiums for faculty/staff coverage, 50% for dependent child(ren) coverage, and 25% 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 include 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/.

**2015 Changes to Medical Plan Design and Medical Coverage**

Beginning 1/1/2015, there will be some changes to plan design and coverage under both medical plans. The most noteworthy changes are summarized below.

- The emergency room copay will increase from $75 to $150.

- There are several changes to the prescription drug benefit:
  - The copays, deductible, and coinsurance required for prescription drugs will apply to the out-of-pocket (OOP) maximum.
  - Generic over-the-counter drugs to treat nicotine dependency will be covered.
  - Generic emergency birth control drugs will be covered in full.

- The out-of-pocket (OOP) maximum will increase by $500. As referenced above, all prescription drug copays will apply to the OOP maximum, which means that individuals who purchase prescription drugs under the plan will reach the OOP maximum more quickly than in the past. As an example, the following are the changes to the OOP maximum for employee only in-network coverage:
  - High deductible plan: Increase from $3,500 to $4,000
  - Low deductible plan: Increase from $2,200 to $2,700

Refer to Table 1 later in this guide for the new OOP maximums for all coverage levels.
• There are expanded mental health and chemical dependency benefits, including:
  o expanded benefits for medically-necessary residential treatment for psychiatric conditions and chemical dependency, as long as the facility is state-licensed or approved to provide residential treatment;
  o expanded benefits related to family and marital counseling;
  o physical, occupational and speech therapy for psychiatric conditions, such as autism spectrum disorders, will be covered for members of all ages;
  o there is no longer a 12-hour limit for the psychological and neuropsychological testing benefit; and
  o detoxification will be covered in any medically-necessary setting.

• If polyps are found during a screening colonoscopy, their removal will be covered as part of the preventive service.

• The plan will cover sexual reassignment surgery that is medically necessary and not cosmetic.

• The plan will allow members online and telephone access to their health care providers (some restrictions apply) and will cover these services as it does any in-person office visit.

• The plan will no longer require a transplant waiting period and will no longer have a $75,000 maximum for transplant donor costs.

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/.

Form W-2 Reporting
The total value of your 2014 medical coverage premiums will be included on your 2014 Form W-2 that you will receive in January 2015. 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
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 1 – Medical Plan Comparison

<table>
<thead>
<tr>
<th>Medical</th>
<th>High Deductible HRA Plan</th>
<th>Low Deductible PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$1,500 Individual</td>
<td>$3,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$3,000 Family</td>
<td>$6,000 Individual</td>
</tr>
<tr>
<td>University’s HRA</td>
<td>Up to $750 Individual</td>
<td>N/A</td>
</tr>
<tr>
<td>Contribution</td>
<td>Up to $1,500 Family</td>
<td>N/A</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$4,000 Individual</td>
<td>$8,500 Individual</td>
</tr>
<tr>
<td>(Includes Deductible,</td>
<td>$8,000 Family</td>
<td>$17,000 Family</td>
</tr>
<tr>
<td>Copays, Coinsurance and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Copays)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care*</td>
<td>Both plans (in-network and out-of-network):</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Covered in full with no cost-share required</td>
<td></td>
</tr>
<tr>
<td>Non-Preventive Care</td>
<td>Deductible and Coinsurance</td>
<td>$20 then Deductible and Coinsurance</td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Both plans (in-network and out-of-network):</td>
<td></td>
</tr>
<tr>
<td>(Waived if Admitted)</td>
<td>$150 Copay then Deductible and Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Prescription Retail</td>
<td>$10 Generic</td>
<td>$10 Generic</td>
</tr>
<tr>
<td>(30-day supply)</td>
<td>$30 Preferred Brand</td>
<td>$30 Preferred Brand</td>
</tr>
<tr>
<td></td>
<td>$60 Non-Preferred</td>
<td>$60 Non-Preferred</td>
</tr>
<tr>
<td>Prescription Mail Order</td>
<td>$20 Generic</td>
<td>$20 Generic</td>
</tr>
<tr>
<td>(90-day supply)</td>
<td>$60 Preferred Brand</td>
<td>$60 Preferred Brand</td>
</tr>
<tr>
<td></td>
<td>$120 Non-Preferred</td>
<td>$120 Non-Preferred</td>
</tr>
<tr>
<td>Vision Exam</td>
<td>Deductible and Coinsurance</td>
<td>$20 then Deductible and Coinsurance</td>
</tr>
</tbody>
</table>

*This benefits summary is designed to give you the information and details you need to better understand your medical benefit options. The actual plan documents take precedence over this summary. For additional details regarding the benefits provided on each medical plan, see pugetsound.edu/about/offices--services/human-resources/benefits.*

* 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/ and view the document titled “Non-grandfathered plans preventive health benefits.”

For additional information about medical plan benefits, you may also refer to the Summary of Benefits 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 9-11 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% of your eligible expenses for the rest of the plan year. **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% of your eligible expenses for the rest of the plan year. **This plan has a lower deductible but you pay more towards premiums out of each paycheck (vs. the**
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.

2015 Medical Plan Costs by Coverage Category
The following are 2015 monthly costs for each of the two Premera Blue Cross medical plans:

<table>
<thead>
<tr>
<th>Table 2 – Monthly Medical Plan Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Deductible HRA Plan</td>
</tr>
<tr>
<td>Premium Total</td>
</tr>
<tr>
<td>Faculty &amp; Staff Share*</td>
</tr>
<tr>
<td>Puget Sound Share</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
</tr>
<tr>
<td>You, Spouse/Partner &amp; Child(ren)</td>
</tr>
<tr>
<td>Low Deductible PPO Plan</td>
</tr>
<tr>
<td>Premium Total</td>
</tr>
<tr>
<td>Faculty &amp; Staff Share*</td>
</tr>
<tr>
<td>Puget Sound Share</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
</tr>
<tr>
<td>You, Spouse/Partner &amp; Child(ren)</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 and for the dependent children of your domestic partner are taken on an after-tax basis. You will also be charged imputed income for the coverage of your domestic partner and your domestic partner’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 2015 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 funds 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 in the section called 2015 Flexible Spending Accounts.

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. In most cases, 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 2015 claims must be submitted to ConnectYourCare by March 31, 2016.

**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 prescription drug copays 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>Medical Services</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>High Blood Pressure Medicine * (Preferred Brand)</td>
</tr>
<tr>
<td>Two Diabetes Medications* (One generic and one preferred brand)</td>
</tr>
<tr>
<td>Annual Premium (Employee Only)</td>
</tr>
<tr>
<td>Total Estimated Faculty/Staff Expenses</td>
</tr>
</tbody>
</table>

* Reminder: copays 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.

**Use of HRA for Domestic Partner and/or the Dependent Child of a Domestic Partner**

IRS regulations require that if any HRA funding is provided to your domestic partner and/or the dependent child of your domestic partner, the fair market value of the HRA funding be added to your gross salary as though you received it as income, and then taxed.

**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.

<table>
<thead>
<tr>
<th>Table 4 – Participating Prescription Copays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Retail (30-day supply)</strong></td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Preferred Brand</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
</tr>
</tbody>
</table>

**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 copay 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 (with and without use or insurance benefit) 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. 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 1.800.810-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.

2015 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 and/or the child or your domestic partner are also eligible for coverage under the dental plan, but the IRS requires that their premium be paid 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>$ 56</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
<td>$112</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
<td>$127</td>
</tr>
<tr>
<td>You, Spouse/Partner &amp; Child(ren)</td>
<td>$183</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% (not subject to annual deductible):
- Oral exams and prophylaxis (two per calendar year)
- Topical fluoride application for children under the age of 20 (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%:
- Emergency palliative treatment
- Simple fillings
Major Services are subject to the annual deductible then covered at 50%:

- 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% of the allowable charges up to a lifetime maximum of $1,000 per participant.

2015 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.

<p>| Table 6 – Unum Voluntary Life Insurance – Monthly Premiums* |
|---------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|</p>
<table>
<thead>
<tr>
<th>Age as of 1/1/2015</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 30</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 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 $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).
- 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 domestic partner or the child of a domestic partner are paid on an after-tax basis.

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

| Table 7 – Voluntary AD&D Insurance Monthly Premiums by Coverage Category* |
|------------------|--------------|--------------|-----------------|------------------|--------------|--------------|
| AD&D             | You          | Spouse/Partner | Child(ren)     | AD&D             | You          | Spouse/Partner |
| $ 10,000         | $0.26        | $0.26         | $0.26          | $160,000         | $4.16        | $4.16         |
| $ 20,000         | $0.52        | $0.52         | $0.52          | $170,000         | $4.42        | $4.42         |
| $ 30,000         | $0.78        | $0.78         | n/a            | $180,000         | $4.68        | $4.68         |
| $ 40,000         | $1.04        | $1.04         | n/a            | $190,000         | $4.94        | $4.94         |
| $ 50,000         | $1.30        | $1.30         | n/a            | $200,000         | $5.20        | $5.20         |
| $ 60,000         | $1.56        | $1.56         | n/a            | $210,000         | $5.46        | $5.46         |
| $ 70,000         | $1.82        | $1.82         | n/a            | $220,000         | $5.72        | $5.72         |
| $ 80,000         | $2.08        | $2.08         | n/a            | $230,000         | $5.98        | $5.98         |
| $ 90,000         | $2.34        | $2.34         | n/a            | $240,000         | $6.24        | $6.24         |
| $100,000         | $2.60        | $2.60         | n/a            | $250,000         | $6.50        | $6.50         |
| $110,000         | $2.86        | $2.86         | n/a            | $260,000         | $6.76        | $6.76         |
| $120,000         | $3.12        | $3.12         | n/a            | $270,000         | $7.02        | $7.02         |
| $130,000         | $3.38        | $3.38         | n/a            | $280,000         | $7.28        | $7.28         |
| $140,000         | $3.64        | $3.64         | n/a            | $290,000         | $7.54        | $7.54         |
| $150,000         | $3.90        | $3.90         | n/a            | $300,000         | $7.80        | $7.80         |

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

### 2015 LONG-TERM DISABILITY

A long-term disability insurance policy is purchased by the university when one of the following conditions is satisfied:

1. you have completed 12 consecutive months of service at Puget Sound; or
2. you provide documentation to Human Resources that you were covered by a total disability plan within three months before employment with Puget Sound, and the policy provided income benefits for five or more years of total disability.

The university’s long-term disability insurance provides payments equal to 60% of covered salary after a six month waiting period. In addition, the plan includes a retirement premium waiver benefit which provides for continuing contributions to the retirement contracts during periods of disability.

### 2015 SHORT-TERM DISABILITY INSURANCE (UNUM LIFE INSURANCE COMPANY)

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, if applicable. 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.

-14-
Please note: Puget Sound must maintain a minimum participation rate of 25% of those eligible for this benefit. If participation is below 25%, Unum may not provide this benefit.

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

- The benefit is equal to 60% 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 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 (provided to faculty and staff members in benefit-eligible positions .75 FTE and 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 (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, 2014, in order to enroll you on short-term disability benefits in 2015. You will not be enrolled on 2015 short-term disability benefits if your Unum approval date is after December 31, 2014, 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 8 – Monthly Rate Per $10 of Covered Benefit

<table>
<thead>
<tr>
<th>Age as of 1/1/2015</th>
<th>Rate</th>
<th>Age as of 1/1/2015</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>$0.54</td>
<td>45-49</td>
<td>$0.42</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.60</td>
<td>50-54</td>
<td>$0.50</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.52</td>
<td>55-59</td>
<td>$0.68</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.42</td>
<td>60-64</td>
<td>$0.86</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.40</td>
<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 1/1/2015</th>
<th>$20,000</th>
<th>$40,000</th>
<th>$60,000</th>
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<tr>
<td>&lt;24</td>
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<td>$24.92</td>
<td>$37.38</td>
<td>$49.85</td>
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<td>25-29</td>
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<td>$41.54</td>
<td>$55.38</td>
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</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>
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<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>
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<td>$47.08</td>
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<td>$79.38</td>
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<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>

2015 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 2015 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, 2015. (Different date restrictions will apply when a faculty or staff member’s employment ends before December 31, 2015. See the section called 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.

**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.

- 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.
- 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.
- 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 your initial enrollment information is set up.

**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 (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:
  - 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 2015 claims to ConnectYourCare no later than March 31, 2016**, in order to be reimbursed for eligible expenses. (Different deadlines may apply when a faculty or staff member’s employment ends before December 31, 2015. 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 for proper postage. When envelopes do not have a return address, Mail Services will forward envelopes to Human Resources where they will be opened and returned to the sender for 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 ([irs.gov](http://irs.gov)).

<table>
<thead>
<tr>
<th>Health Care FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>o 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>
</tr>
<tr>
<td>o Medical deductibles, coinsurance, and copays (the portion of medical charges you pay)</td>
<td>o 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>
</tr>
<tr>
<td>o Most medical expenses not covered by a medical plan, such as hearing aids, glasses, contact lenses, and prescribed over-the-counter drugs</td>
<td>o 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>
</tr>
<tr>
<td>o Dental deductibles and copays</td>
<td></td>
</tr>
<tr>
<td>o Most dental expenses not covered by a dental plan</td>
<td></td>
</tr>
</tbody>
</table>

| Ineligible Expenses |  |
|---------------------|  |
| o 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 | o Care provided by your spouse, your child under age 19, or anyone you claim as a tax dependent |
| o Cosmetic surgery, unless required to treat an illness, injury, or deformity arising from a congenital abnormality | o Expenses for food, clothing, overnight camp, entertainment, and education beginning when your qualified dependent enters the first grade |
| o Funeral and burial expenses | o Expenses for dependent care so that you or your spouse can perform volunteer work |
| o Household and domestic help | o Transportation expenses |
| o Custodial care in an institution | o Charges for a convalescent nursing home |
| o Health club dues |  |
| o Expenses already reimbursed by an HRA |  |
| o Premiums for other health care plans (such as your spouse’s) |  |
| o 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 |  |
**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, 2016. 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 the section called *Continued Benefits Coverage under COBRA* for more information.

For the Dependent Care FSA, you may submit claims for eligible expenses incurred through December 31, 2015, including claims incurred after your termination date. All claims must be submitted to ConnectYourCare by March 31, 2016.

**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 the section called Continued Benefits Coverage under COBRA for more information.

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

Flexible Spending Account Decisions for 2015
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:

- 2015 Dependent Demographics and Benefits Re-Enrollment Form (required from everyone during the Fall 2014 open enrollment)
- 2015 Benefits Election and Enrollment Form (required if you are newly-eligible for benefits or are making changes to 2015 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; Unum’s approval of such evidence of insurability applications must be dated on or before December 31, 2014, or 2015 benefits will not be authorized)
- 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 2015 enrollment will automatically default to the High Deductible HRA medical plan for yourself only.

ANNUAL OPEN ENROLLMENT: If you are a current benefits-eligible faculty or staff member, flexible benefit changes are allowed during the open enrollment period from November 3-21, 2014. If an enrollment or re-enrollment form is not submitted to Human Resources by November 21, 2014, your 2015 benefit elections will remain the same as your 2014 elections except you will have no Flexible Spending Account deductions, even if you elected them for 2014.

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 the section called Making Election Changes in the Future for more details about qualifying status changes.
Making Election Changes in the Future

Special Enrollment Period Rules
Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan’s open enrollment period. There are two types of special enrollment:

- **Loss of Eligibility for Other Coverage**: In this circumstance, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for employee and family because the family already has coverage through the spouse’s/ partner’s plan. Coverage under the spouse’s/ partner’s plan ceases. That employee then can request enrollment in his/her own employer’s plan for employee and dependents.

- **Certain Life Events**: In this circumstance, employees, spouses, and new dependents are permitted to enroll because of marriage, birth, adoption, placement for adoption, or being responsible for a foster child.

A special enrollment right also arises for employees and their dependents who lose coverage under a State Children’s Health Insurance Program or Medicaid or who are eligible to receive premium assistance under those programs.

Special enrollment is **not permitted** due to enrollment or un-enrollment in 1) an ACA-sponsor 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, placement for adoption, or assuming legal responsibility for a foster child triggers a special enrollment period for each new dependent. To qualify, the special enrollment request must be made within the required time frame described in the Status Change section.

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 30 days, unless a different timeframe is otherwise listed next to the item.

- Divorce or legal separation that results in you losing coverage under your spouse’s health insurance

- The death of your spouse/partner leaves you without coverage under his or her plan

- Change in the number of your dependents, other than a newborn or an adopted newborn child
  - 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 adoption or placement for adoption, coverage begins on the date the event occurred.

- 21
In the case of death, the full premium is charged for the month in which the death occurs.

- Birth, adoption, placement for adoption, or assuming legal responsibility for a foster child (within 60 days)
  - Under the Erin Act newborns are automatically covered under the mother’s medical plan for the first 21 days of life to allow the family time to enroll the newborn for medical coverage
  - If the newborn is enrolled on a Puget Sound medical plan, billing is handled as follows:
    - For birth dates on the 1st – 16th of the month, the new benefit premium goes into effect the first of the birth month
    - For birth dates on the 17th to end of the month, the new premium will be effective the first of the month following the birth
    - If premiums have been missed, they will be deducted on the next available paycheck
  - If paperwork is received within 60 days, coverage is effective the date the legal guardianship/foster placement
  - When the court order terminates or expires, the child is no longer an eligible child

- In the case of a foster child, there must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date; if paperwork is received within 60 days, coverage is effective the date the legal guardianship/foster placement

- Your spouse's/partner's employment ends, as does coverage under his/her employer's health plan

- Your work hours are reduced to the point you are no longer covered by the health plan

- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a benefit

- An individual enrolled on the plan no longer lives or works in the plan’s service area

- Loss or gain of eligibility under another employer's plan

- Enrollment in or loss of Medicare coverage

- 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 year.
Below are tables reflecting the monthly faculty/staff share of 2015 and 2014 benefit premiums. Your semi-monthly payroll deductions will be equivalent to half of the monthly premium listed. 2015 Medical Plan and Voluntary Dental Plan premiums increased. There were no premium changes for the Voluntary Life, Voluntary AD&D or Short-Term Disability Plans. However, because the premiums for Voluntary Life and Short-Term Disability Insurance are based on your age as of January 1 of the covered year, your 2015 premiums for those benefits may increase if you change age brackets as of January 1, 2015.

### MEDICAL PLANS (PREMERA BLUE CROSS)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Deductible HRA Plan - Subscriber (NO COST TO YOU)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High Deductible HRA Plan - Subscriber &amp; Spouse/Partner</td>
<td>537</td>
<td>478</td>
</tr>
<tr>
<td>High Deductible HRA Plan - Subscriber &amp; Child(ren)</td>
<td>214</td>
<td>191</td>
</tr>
<tr>
<td>High Deductible HRA Plan - Subscriber &amp; Family</td>
<td>715</td>
<td>637</td>
</tr>
<tr>
<td>Low Deductible PPO Plan - Subscriber</td>
<td>130</td>
<td>107</td>
</tr>
<tr>
<td>Low Deductible PPO Plan - Subscriber &amp; Spouse/Partner</td>
<td>840</td>
<td>731</td>
</tr>
<tr>
<td>Low Deductible PPO Plan - Subscriber &amp; Child(ren)</td>
<td>428</td>
<td>366</td>
</tr>
<tr>
<td>Low Deductible PPO Plan - Subscriber &amp; Family</td>
<td>1,150</td>
<td>1,005</td>
</tr>
<tr>
<td>Waiving medical coverage</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### VOLUNTARY DENTAL PLAN (PREMERA BLUE CROSS)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optima Dental – Subscriber only</td>
<td>56</td>
<td>53</td>
</tr>
<tr>
<td>Optima Dental - Subscriber &amp; Spouse/Partner</td>
<td>112</td>
<td>105</td>
</tr>
<tr>
<td>Optima Dental - Subscriber &amp; Child(ren)</td>
<td>127</td>
<td>120</td>
</tr>
<tr>
<td>Optima Dental - Subscriber &amp; Family</td>
<td>183</td>
<td>172</td>
</tr>
<tr>
<td>Waiving dental coverage</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### VOLUNTARY LIFE INSURANCE (UNUM)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional coverage from $0 to $175,000</td>
<td>Same premiums as 2014; based on your age as of January 1, 2015</td>
<td>Based on your elected coverage and your age as of January 1, 2014</td>
</tr>
</tbody>
</table>

### VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE (UNUM)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only</td>
<td>Same premiums as 2014; see premium table below</td>
<td>Premiums are based on your elected coverage level</td>
</tr>
<tr>
<td>Spouse/Partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Child(ren)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SHORT-TERM DISABILITY INSURANCE (UNUM)

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Only</td>
<td>Same premiums as 2014; based on your age as of January 1, 2015</td>
<td>Based on your age and salary</td>
</tr>
</tbody>
</table>
This worksheet is a tool to aid you in completing the 2015 Benefits Election and Enrollment Form. The figures you arrive at on the worksheet may be directly transferred to the Election and Enrollment Form to be sent to Human Resources. Please do not submit this worksheet to Human Resources.

**Medical Plan Election (Premera Blue Cross)**
Refer to the election guide booklet for a detailed description of the two medical plans offered by Premera Blue Cross. The table below shows your monthly costs for the medical plans.

<table>
<thead>
<tr>
<th>Coverage Categories</th>
<th>High Deductible HRA Plan</th>
<th>Low Deductible PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No university coverage*</td>
<td>$ 0</td>
<td>$ 0</td>
</tr>
<tr>
<td>You</td>
<td>$ 0</td>
<td>$ 130</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
<td>$ 537</td>
<td>$ 840</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
<td>$ 214</td>
<td>$ 428</td>
</tr>
<tr>
<td>You &amp; Family</td>
<td>$ 715</td>
<td>$1,150</td>
</tr>
</tbody>
</table>

Enter the cost of your selection here $  

*Only if you have adequate health coverage elsewhere

**Dental Plan Election (Premera Blue Cross)**
Refer to the election guide booklet for a detailed description of the Premera Blue Cross Optima Dental Plan. The table below shows your monthly costs for the dental plan.

<table>
<thead>
<tr>
<th>Coverage Categories</th>
<th>Dental Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No university coverage</td>
<td>$ 0</td>
</tr>
<tr>
<td>You</td>
<td>$ 56</td>
</tr>
<tr>
<td>You &amp; Spouse/Partner</td>
<td>$112</td>
</tr>
<tr>
<td>You &amp; Child(ren)</td>
<td>$127</td>
</tr>
<tr>
<td>You &amp; Family</td>
<td>$183</td>
</tr>
</tbody>
</table>

Enter the cost of your selection here $  

**Voluntary Life Insurance (Unum)**
What you are electing is additional life insurance, above the $25,000 the university is already purchasing for you. Refer to the election guide booklet for a detailed explanation of Group Life Insurance.

Newly hired faculty and staff members may elect any level of coverage without providing evidence of insurability (EOI). In subsequent election periods, you can increase your voluntary life coverage by one level until you reach the maximum voluntary life insurance benefit of $175,000.

To determine your monthly costs, locate your age as of January 1, 2015, on the chart below. Next, find the corresponding column with the amount of additional life insurance you wish to purchase. For example, the monthly cost for a 43-year-old electing $50,000 in additional coverage is $5.00 per month. The cost will remain the same for the entire calendar year, even if you change age categories during 2015.
### Voluntary Life Insurance Monthly Rates

<table>
<thead>
<tr>
<th>Age as of 1/1/15</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>
<th>No Additional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</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>
<td>$0</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>
<td>$0</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>
<td>$0</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>
<td>$0</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>
<td>$0</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>
<td>$0</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>
<td>$0</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>
<td>$0</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>
<td>$0</td>
</tr>
<tr>
<td>70+</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>
<td>$0</td>
</tr>
</tbody>
</table>

Enter the **amount** of your election here (e.g. $50,000) $  
Enter the **cost** of your election here (e.g. $5.00) $

### Voluntary Accidental Death and Dismemberment (AD&D) Insurance (Unum)

What you are electing is *additional* AD&D insurance, above the $25,000 the university is already purchasing for you. You may elect up to $300,000 for yourself, up to $300,000 for your spouse/partner, and up to $20,000 for your child(ren). Spouse and child elections may not be greater than your election.

<table>
<thead>
<tr>
<th>AD&amp;D Election</th>
<th>You</th>
<th>Spouse/Partner</th>
<th>Dependent Child(ren)</th>
<th>AD&amp;D Election</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>
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<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>
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<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>
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<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>

Circle the coverage you want for yourself, your spouse/partner and your child(ren)  
Enter the **cost** of the election for your own coverage here (e.g. $7.80) $  
Enter the **cost** of the election for your spouse/partner here (e.g. $3.90) $  
Enter the **cost** of the election for your child(ren) here (e.g. $0.52) $  

**Add the 3 lines together** to find the total cost of all voluntary AD&D elections $
**Voluntary Short-Term Disability Insurance (Unum)**

This insurance coverage pays a percentage of your gross weekly salary if you cannot work due to pregnancy disability or other covered injury or illness and provides added financial security during such times. 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.

To determine your premium use the table below along with the table at the end of this section:

<table>
<thead>
<tr>
<th>Age as of January 1, 2015</th>
<th>Monthly Rate* Per $10 of Covered Benefit</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>

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

<table>
<thead>
<tr>
<th>Annual Salary</th>
<th>Divide by Weeks</th>
<th>Weekly Benefit Percent</th>
<th>Weekly Benefit</th>
<th>To Find Rate Per $10 of Benefit</th>
<th>Rate By Age (See Table Above)</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30,000</td>
<td>÷ 52</td>
<td>x 60%</td>
<td>$346.15</td>
<td>÷ 10</td>
<td>x $0.52</td>
<td>$18.00</td>
</tr>
</tbody>
</table>

Enter your information to calculate your monthly premium:

<table>
<thead>
<tr>
<th>Your Annual Salary*</th>
<th>Divide by Weeks</th>
<th>Weekly Benefit Percent</th>
<th>Weekly Benefit</th>
<th>To Find Rate Per $10 of Benefit</th>
<th>Rate By Age (See First Table in This Section)</th>
<th>Your Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ _______</td>
<td>÷ 52</td>
<td>x 60%</td>
<td>$ _______</td>
<td>÷ 10</td>
<td>x $ _______</td>
<td>$ _______</td>
</tr>
</tbody>
</table>

*This can be obtained from your contract, offer letter, your Total Compensation Statement or by calling Human Resources at 253.879.3369.

**Health Care Flexible Spending Account**

Many types of health care expenses are eligible for reimbursement through your Health Care Flexible Spending Account. The following page lists some examples of expenses that can qualify, along with some room for you to estimate what your expenses might be in each area. This list is not all-inclusive; you can obtain a comprehensive list from the Internal Revenue Service's (IRS) Publication 502 on their website at [www.irs.gov](http://www.irs.gov).
Projected Expenses for 2015

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>Copays</th>
<th>Coinsurance</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Dental services

Devices, equipment & supplies (for home use)¹

Eyeglasses & contact lenses/solution for medical reasons

Hospital or hospice services

Mental health services

Optical services

Prescriptions

Service animal²

Other eligible health care expenses

$ $ $ $

Totals

¹ Orthopedic appliances, durable medical equipment, colostomy supplies, post-mastectomy bras, and prosthetic devices.

² You can include in medical expenses the cost of a service animal to be used by a visually-impaired or hearing-impaired person. You can also include the cost of a service animal trained to assist persons with other physical disabilities. Amounts you pay for the care of these animals are also medical expenses.

Your total estimated annual expenses divided by the number of months you will be on the plan during 2015 will be the monthly amount to be deposited into your Health Care FSA. Since faculty and staff are paid semi-monthly, your monthly contribution will be divided in half and deposited each paycheck.

<table>
<thead>
<tr>
<th>Annual contribution (maximum $2,500)</th>
<th>Divide by # of months you will be on the plan in 2015</th>
<th>Monthly contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ _________</td>
<td>_________</td>
<td>$ _________</td>
</tr>
</tbody>
</table>

Dependent Care Flexible Spending Account

Eligible expenses are:

- Charges for the care of your children, age 12 and under, so you can work
- Charges for the care of children or adults of any age who are unable to care for themselves because of physical or mental handicap. A person qualifying for this type of care must spend at least eight hours a day in your home and you must declare him or her as a dependent on your tax return. Nursing home expenses do not qualify.

Your total estimated annual expenses divided by the number of months you will be on the plan during 2015 will be the amount to be deposited in your Dependent Care Flexible Spending Account on a monthly basis. Since faculty and staff are paid semi-monthly, your monthly contribution will be divided in half and contributed each paycheck. This amount cannot exceed $5,000 for the calendar year. Below is a table to help you estimate your dependent care expenses. Remember to account for rate changes due to the older age of the child, vacation days, sick days and holidays:

<table>
<thead>
<tr>
<th>Weekly cost of care</th>
<th># of weeks of care expenses through 12/31/2015</th>
<th>Estimated annual expenses (maximum $5,000)</th>
<th>Divide by # of months you will be on the plan in 2015</th>
<th>Monthly contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ _______</td>
<td>x _______</td>
<td>$ _______</td>
<td>_______</td>
<td>$ _______</td>
</tr>
</tbody>
</table>
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. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage 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 continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your hours of employment are reduced, or
• Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• 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 of the following qualifying events:
• 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 University of Puget Sound Flexible Benefits Plan, 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. 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 continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:
- The end of employment or 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 (under Part A, Part B, or both).

For all 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.

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a
spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes
To protect your family’s rights, let the Plan Administrator know about 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 Campus location: Howarth Hall #016
Human Resources – Benefits Phone: 253.879.3369
1500 N Warner CMB 1064 Fax: 253.879.2839
Tacoma, WA, 98416-1064 Email: hr@pugetsound.edu

ADMINISTRATIVE INFORMATION ABOUT YOUR BENEFITS

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 Name: University of Puget Sound Total Disability Plan Plan Number: 504

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**

**Statement of ERISA 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/RDP 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.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
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 University of Puget Sound, 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. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits 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.

Special Enrollment Rights
If you are declining enrollment in the University of Puget Sound Flexible Benefits Plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the University of Puget Sound Flexible Benefits Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your
dependents’ other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children’s Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

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, 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 whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status 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: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”.

-33-
**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 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles. Special hours of service eligibility requirements apply to airline flight crew employees.

**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 3 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; and
- 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. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

**For Additional Information**

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**Health Insurance Marketplace Coverage Options**
This notice is available on the Benefits website as a PDF document.

**General Information**
When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

**What is the Health Insurance Marketplace?**
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins again on November 15, 2014 for coverage starting as early as January 1, 2015.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs...
covered by the plan is no less than 60% of such costs. Both of the university-sponsored medical plans meet the minimum value standards.

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. Because University of Puget Sound pays 100% 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.

Since University of Puget Sound offers medical coverage to spouses/partners and dependent children, and the university medical plans meet the affordability and coverage requirements, you may not be eligible for a financial subsidy from the government to help pay for any family 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 afforded for spouse and dependent child coverage on the university-sponsored plans. With federal tax rates in double digits, this is a significant consideration.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| Employer Name: University of Puget Sound | EIN: 91-0564961 |
| Employer Address: 1500 N Warner CMB 1064 | Employer Phone Number: 253.879.3369 |
| City: Tacoma | State: WA | Zip: 98416-1064 |
| Who can we contact about employee health coverage at this job? Human Resources |
| Email Address: hr@pugetsound.edu |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees. 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, we do offer coverage to eligible dependents: The lawful spouse or domestic partner of the subscriber, unless legally separated. A spouse/DP cannot enroll as both a spouse and a subscriber. A dependent child (natural, offspring, legally adopted, legally placed, foster child) who is under 26 years of age.

- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week, if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

**Medicare Part D Prescription Drug Notice from Premera**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with University of Puget Sound 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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 (like an HMO or PPO) 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.

University of Puget Sound has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium if you later decide to 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. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later.

You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. 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.

If you do decide to join a Medicare drug plan, your University of Puget Sound coverage will be affected. Benefits will not be coordinated with a Medicare Part D plan.

If you do decide to join a Medicare drug plan and drop your University of Puget Sound prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. You should also know that if you drop or lose your coverage with University of Puget Sound 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 prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the 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 November to join.

Contact University of Puget Sound Human Resources at 253.879.3369 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, or if this coverage through University of Puget Sound changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If Medicare eligible, 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 or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program for personalized help.
- 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).

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

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Mail Order (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$60</td>
<td>$120</td>
</tr>
</tbody>
</table>

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).

Date: October 15, 2014
Name of Entity/Sender: University of Puget Sound Human Resources
Address: 1500 N. Warner St #1064, Tacoma, WA 98416-1064
Phone Number: 253.879.3369

Premium Assistance under Medicaid and the Children's Health Insurance Program
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (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, 2014. You should contact your state for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Website/Phone Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td><a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a> or 1-855-692-5447</td>
</tr>
<tr>
<td>ALASKA</td>
<td>health.hss.state.ak.us/dpa/programs/medicaid/ or (Outside of Anchorage): 1-888-318-8890 or (Anchorage): 907-269-6529</td>
</tr>
<tr>
<td>ARIZONA</td>
<td><a href="http://www.azahcccs.gov/applicants">www.azahcccs.gov/applicants</a> or (Outside of Maricopa County): 1-877-764-5437 or (Maricopa County): 602-417-5437</td>
</tr>
<tr>
<td>COLORADO</td>
<td><a href="http://www.colorado.gov/">www.colorado.gov/</a> or (In state): 1-800-866-3513 or (Out of state): 1-800-221-3943</td>
</tr>
<tr>
<td>FLORIDA</td>
<td><a href="https://www.fmedicaidprecovery.com/">https://www.fmedicaidprecovery.com/</a> or 1-877-357-3268</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>dch.georgia.gov/ (Click on Programs, then Medicaid, then HIPP) or 1-800-869-1150</td>
</tr>
<tr>
<td>IDAHO</td>
<td>healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx or 1-800-926-2588</td>
</tr>
<tr>
<td>INDIANA</td>
<td><a href="http://www.in.gov/fssa">www.in.gov/fssa</a> or 1-800-889-9949</td>
</tr>
<tr>
<td>IOWA</td>
<td><a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> or 1-888-346-9562</td>
</tr>
<tr>
<td>KANSAS</td>
<td><a href="http://www.kdheks.gov/hcf/">www.kdheks.gov/hcf/</a> or Phone: 1-800-792-4884</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>chfs.ky.gov/dms/default.htm or 1-800-635-2570</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td><a href="http://www.lahipp.dhh.louisiana.gov">www.lahipp.dhh.louisiana.gov</a> or 1-888-695-2447</td>
</tr>
<tr>
<td>MAINE</td>
<td><a href="http://www.maine.gov/dhhs/of/public-assistance/index.html">www.maine.gov/dhhs/of/public-assistance/index.html</a> or 1-800-977-6740 or TTY 1-800-977-6741</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td><a href="http://www.mass.gov/MassHealth">www.mass.gov/MassHealth</a> or 1-800-462-1120</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td><a href="http://www.dhs.state.mn.us/">www.dhs.state.mn.us/</a> (Click on Health Care, then Medical Assistance) or 1-800-657-3629</td>
</tr>
<tr>
<td>MISSOURI</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> or 573-751-2005</td>
</tr>
<tr>
<td>MONTANA</td>
<td>medicaidprovider.bhs.mt.gov/clientpages/clientindex.shtml or 1-800-694-3084</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> or 1-855-632-7633</td>
</tr>
<tr>
<td>NEVADA</td>
<td>dwss.nv.gov/ or 1-800-992-0900</td>
</tr>
<tr>
<td>NEW HAMPSHIRE</td>
<td><a href="http://www.dhhs.nh.gov/oi/documents/hippapp.pdf">www.dhhs.nh.gov/oi/documents/hippapp.pdf</a> or 603-271-5218</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>Medicaid: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> or 609-631-2392; CHIP: <a href="http://www.njfamilycare.org/index.html">www.njfamilycare.org/index.html</a> or CHIP Phone: 1-800-701-0710</td>
</tr>
<tr>
<td>NEW YORK</td>
<td><a href="http://www.nyhealth.gov/healthcare/medicaid/">www.nyhealth.gov/healthcare/medicaid/</a> or 1-800-541-2831</td>
</tr>
<tr>
<td>N. CAROLINA</td>
<td><a href="http://www.ncdhhs.gov/dma">www.ncdhhs.gov/dma</a> or 919-855-4100</td>
</tr>
<tr>
<td>N. DAKOTA</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">www.nd.gov/dhs/services/medicalserv/medicaid/</a> or 1-800-755-2604</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td><a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a> or 1-888-365-3742</td>
</tr>
<tr>
<td>OREGON</td>
<td><a href="http://www.oregonhealthkids.gov">www.oregonhealthkids.gov</a> or <a href="http://www.hijossaludablesoregon.gov">www.hijossaludablesoregon.gov</a> or 1-800-699-9075</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td><a href="http://www.dpw.state.pa.us/hipp">www.dpw.state.pa.us/hipp</a> or 1-800-692-7462</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td><a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a> or 401-462-5300</td>
</tr>
<tr>
<td>S. CAROLINA</td>
<td><a href="http://www.scdhhs.gov">www.scdhhs.gov</a> or 1-888-549-0820</td>
</tr>
<tr>
<td>S. DAKOTA</td>
<td>dss.sd.gov or 1-888-828-0059</td>
</tr>
<tr>
<td>TEXAS</td>
<td><a href="http://www.gethipptexas.com/">www.gethipptexas.com/</a> or 1-800-440-0493</td>
</tr>
<tr>
<td>UTAH</td>
<td>health.utah.gov/upp or 1-866-435-7414</td>
</tr>
<tr>
<td>VERMONT</td>
<td><a href="http://www.greenmountaincare.org/">www.greenmountaincare.org/</a> or 1-800-250-8427</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Medicaid: <a href="http://www.coverva.org/programs/premium_assistance.cfm">www.coverva.org/programs/premium_assistance.cfm</a> or 1-800-432-5924 CHIP: <a href="http://www.coverva.org/programs/premium_assistance.cfm">www.coverva.org/programs/premium_assistance.cfm</a> or 1-855-242-8282</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td><a href="http://www.hca.wa.gov/medicaid/premiumytm/pages/index.aspx">www.hca.wa.gov/medicaid/premiumytm/pages/index.aspx</a> or 1-800-562-3022 ext. 15473</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td><a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a> or 1-877-598-5820, HMS Third Party Liability</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td><a href="http://www.badgercareplus.org/pubs/p-10095.htm">www.badgercareplus.org/pubs/p-10095.htm</a> or 1-800-362-3002</td>
</tr>
<tr>
<td>WYOMING</td>
<td>health.wyo.gov/healthcarefin/equalitycare or 307-777-7531</td>
</tr>
</tbody>
</table>
To see if any more states have added a premium assistance program since July 31, 2014, 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 AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT
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:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. 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
revoke 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 Protected Health Information.

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.

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. All complaints must be made in writing. You will not be penalized for filing a complaint. You may contact our office at the University of Puget Sound at 252.879.3369.
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 of your PHI that the Plans maintain, including any 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**

**Human Resources**
Email: hr@pugetsound.edu
Location: Howarth 016 (M-F 8-12, 1 – 5 p.m.)
Phone: 253.879.3369
Fax: 253.879.2839

**Premera** (medical insurance, dental insurance, FSA and HRA questions)
Website: www.premera.com
Phone: 1.800.722.1471 [customer service]
1.800.810.BLUE (2583) [out-of-state]
1.800.722.9780 [web support]

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

**TIAA-CREF** (retirement savings plan)
Website: 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]

**Washington Health Benefit Exchange**
Website: www.wahbexchange.org
Phone: 1.855.WAFINDER (923.4633)

**Assist America** (travel assistance program)
Website: medservices@assistamerica.com
Phone: 1.800.872.1414 [within the U.S.]
1.609.986.1234 [outside the U.S.]