2016 Benefits Decision Guide

Open Enrollment

Begins: Monday, February 22, 2016

Ends: Monday, March 7, 2016, 4 PM

Changes: Effective April 1, 2016

Lewis & Clark College – Office of Human Resources 503-768-6235
0615 S.W. Palatine Hill Road, MSC 72 Portland, OR 97219

Dear Colleagues:

It is our pleasure to provide you with this important resource regarding your benefits at Lewis & Clark College. This guide has all of the information you will need for open enrollment and throughout the year so you can make educated decisions that are right for you and your family.

You are encouraged to give your benefits a 'check-up' at least once a year, and open enrollment provides a great opportunity to do so. Use this overview of your benefit choices and how to enroll to help you select the coverage that will meet the needs of you and your family over upcoming year.

If you make no changes during Open Enrollment, your current benefit elections will remain in place through 2016 — with the exception of flexible spending accounts. **FSA elections do not carry over from year to year.** If you want an FSA, you must actively enroll in one during Open Enrollment.

All benefit changes during open enrollment will be done online in Workday! You will receive an email notification and an item in your Workday In-box to start the process on Monday, February 22, 2016.

Questions? We are happy to help!

- Use our Benefit Vendor Contact Sheet to get in touch with plan administrators.
- Visit our 2016 Benefits & Wellness Fair to speak to benefit vendors on Feb 24, 2016 from 10-1:30pm in Templeton.
- Contact our Benefits Analyst, Helen DeVol, in Human Resources anytime by email helen@lclark.edu or phone 503-768-6234

We look forward to helping you with any of your benefit needs,

Your Benefit Team

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Benefits Checklist

Open Enrollment is a great time to review your existing benefit plans, evaluate any anticipated needs, learn more about what benefits are available, and make adjustments for the upcoming plan year.

Remember: Open Enrollment ends Monday, March 7th. All changes must be completed in Workday no later than 4:00 pm PST on Monday, March 7, 2016.

Review…

- ✓ Review your benefits in Workday.
  - o Sign in to Workday
  - o Click on the Benefits Worklet on your home screen
  - o View Benefits Elections under VIEW.
- ✓ This 2016 Open Enrollment Packet.
- ✓ Your beneficiary designations. Are there any updates to make?

Get Informed…

- ✓ Attend the Benefits & Wellness Fair on Wednesday, February 24th in Stamm from 10am - 1:30pm
- ✓ Visit the Human Resources Benefits Open Enrollment webpage - https://go.lclark.edu/open_enrollment
- ✓ Contact the Office of Human Resources with questions: 503-768-6235 or HR@lclark.edu
- ✓ Go Online. Our Health and dental insurance providers make a number of tools and resources available through their websites that can help support your decision-making process. See the contact sheet at the end of this booklet for more information.

Make Changes…

- ✓ Change your medical or dental plan enrollment.
- ✓ Add or remove spouse/domestic partner and dependents.
- ✓ Sign up for Flexible Spending Account(s).

No Changes?

- ✓ Do nothing – If you do not make enrollment changes during Open Enrollment, your participation in your medical and dental insurance will remain the same but at the new contribution rates. **If you do not enroll in the Allegiance FSA reimbursement account, you will not be a participant in 2016-17.**

Dates to Remember

Open Enrollment is February 22rd – March 7th

All benefit changes during open enrollment will be done online in Workday! You will receive an email notification and an item in your Workday In-box to start the process on Monday, February 22, 2016.

Workday Drop-In Sessions:

If you would like to have help in completing online Open Enrollment in Workday, then please feel free to "Drop In" at the Mac Lab Open Houses in Templeton on the following dates and times:

1. **Tuesday, February 23: 10 am – 12 pm**
2. **Thursday, March 3: 1pm – 3 pm**
3. **Monday, March 7: 2pm – 4 pm**

If these times do not work within your schedule, but you would still like some assistance, please contact HR to schedule an individual appointment.

Benefits & Wellness Fair:

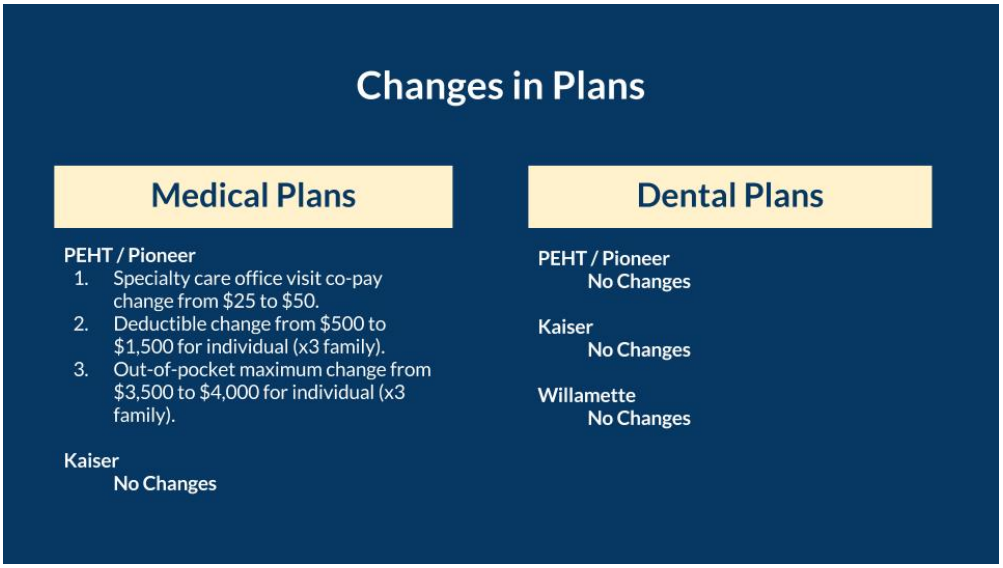
Wednesday, February 24th, 10 a.m. to 1:30 p.m. in Stamm.

The College is pleased to offer a fun and informative Wellness Fair as a part of our annual Benefits Open Enrollment. The theme this year is ***Superheroes, Super Health - Your Hero Starts from Within.***

Over 25 Wellness vendors will provide free screenings, massage sessions, holistic health and nutritional information. In addition to the Human Resources department, representatives from all of the College's benefits plans will be on hand to assist you and answer questions.

Don't miss the raffle of prizes generously donated by our plan representatives…drop by the Fair and sign up for the drawings! **Bring your postcard invitation to enroll in the grand prize drawing for a $100 New Seasons Gift Card.**

Insurance Plan Changes



Dental plan changes: There will be no changes to Willamette Dental, Kaiser and Regence (PEHT) dental plan coverages. Please refer to the rate sheets to see changes in premiums.

Kaiser medical plan changes: There will be no changes to the Kaiser benefit plan coverage. Please refer to the rate sheets to see changes in premiums.

Regence (PEHT) medical plan changes: The following three changes are effective 4/1/2016. Please refer to the rate sheets to see changes in premiums.

1. Copay for specialty care office visits will change from $25 to $50. (Primary Care Provider office visit copay will continue to be $25)

   A Specialist is a provider whose training and expertise is in a specific area of medicine. For example: cardiology, neurology or oncology. For these services, the $50 copay would apply.

   Below is a list of primary care provider types ***not*** subject to the specialist copay:
   - Family Practice
   - Geriatrics
   - General Practice
   - GYN/OBGYN
   - Internal Medicine
   - Midwife
   - Obstetrics
   - Pediatrics

- Preventive Medicine
- Mental Health, which includes Psychiatry

Additional details can be found in the Regence PEHT Summary of Benefits and Coverage.

2. The calendar year deductible will change from $500 to $1,500 for individual coverage (x3 family).

   A deductible is a dollar amount you must pay first for certain services before the insurance begins to pay for that service, such a inpatient hospital stays. Not all services are subject to the deductible, however.

   The following services are ***not*** subject to the deductible:
   - InNetwork Specialty and PCP Office Visits
   - Outpatient Laboratory
   - Outpatient Radiology Service
   - Mental Health Outpatient Office Services
   - Prescriptions
   - InNetwork Preventive Care and Immunizations
   - Urgent Care
   - Emergency Room Services
   - Vision Benefits (Pediatric and Adult)

   Additional details can be found in the Regence PEHT Summary of Benefits and Coverage.

3. The calendar year out of pocket maximum will change from $3,500 to $4,000 for individual coverage (x3 family).

   The Plan Year is April 1 st – March 31 st of each year. Deductibles and out of pocket maximum (OOPM) expenses are measured on the calendar year beginning January 1st of each year.

   For instance, if you enrolled in PEHT as of April 1, 2015, and met your deductible in August, the deductible would start over again in January. The same holds true for the annual OOPM.

   In the next Plan Year, effective April 1 st , the deductible is changing from $500 to $1500. Therefore, even if you've met the $500 deductible prior to April 1 st , the new deductible will apply for the balance of the calendar year. For instance, if you've paid the full $500 prior to April 1 st , you would have a new deductible balance of $1,000 for the rest of 2016 (April – December).

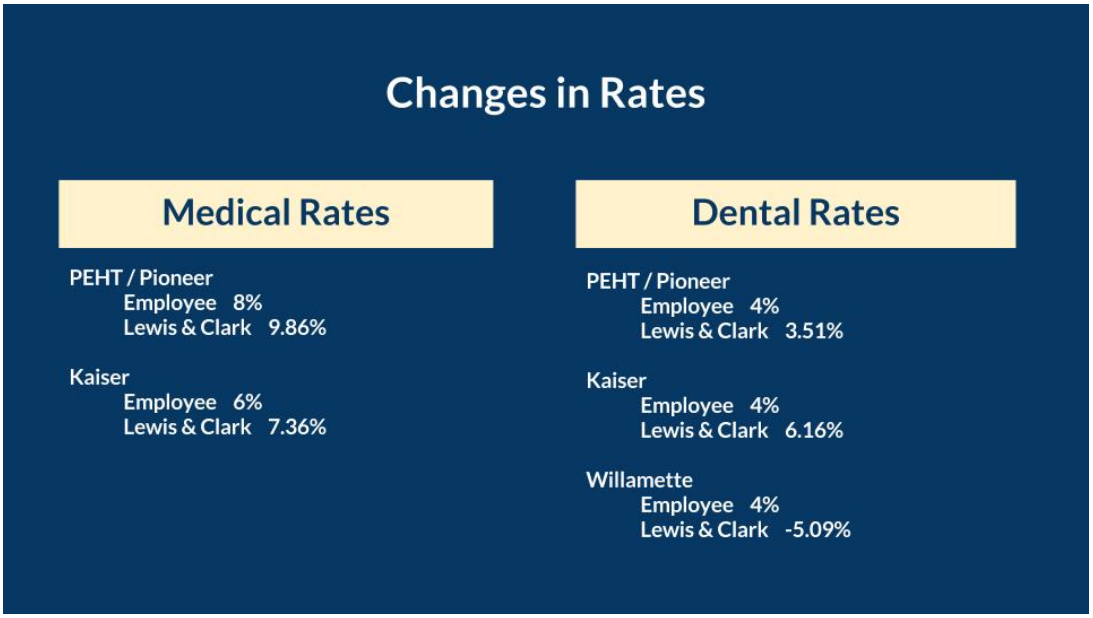
Medical Plan Comparison 2016-2017

Plan Name & Provider Network	PPO (Preferred Provider Organization)		Kaiser Permanente
	Pioneer Educators Health Trust (PEHT) Regence BlueCross/BlueShield Preferred Provider Network *(No PCP/Specialist referral required)*		Kaiser Provider Network *(PCP/Specialist referral required)*
	In-Network	Out-of-Network	In-Network Only
Monthly Employee Premium	Employee Only: $109.09 Employee + 1: $422.79 Family: $609.06		Employee Only: $74.02 Employee + 1: $286.77 Family: $414.44
Annual Deductible	Individual $1,500 Family $4,500	Individual $3,000 Family $9,000	None
Annual Out-of-Pocket Maximum	Individual $4,000 Family $12,000	Individual $8,000 Family $24,000	Individual $1,250 Family $2,500
Primary Care	$25 copay (deductible waived)	Employee pays 40% after deductible	No Charge
Specialty Care	$50 copay (deductible waived)	Employee pays 40% after deductible	$15 copay
Diagnostic Lab & X-ray	Employee pays 20% (deductible waived)	Employee pays 40% after deductible	No charge
Inpatient Stay/Surgery	Employee pays 20% after deductible	Employee pays 40% after deductible	$250 per admission
Outpatient Surgery	Employee pays 20% after deductible	Employee pays 40% after deductible	$15 copay
Urgent Care	$25 co-pay	Employee pays 40%	$35 copay
Emergency Room	$250 co-pay, then employee pays 20% (deductible waived if admitted)		$75 copay plus any other charges that normally apply
Ambulance Services	Employee pays 20% after deductible		$75 copay
Prescription Retail (Up to 30 – day supply)	$20 generic $40 preferred $60 non-preferred		$15 generic $30 preferred / $50 non-preferred *Kaiser Permanente pharmacies and mail-order only*
Mail Order Prescriptions (Up to 90 – day supply)	$30 generic $60 preferred $90 non-preferred		$30 generic / $60 brand name / $100 non-preferred brand name *Kaiser Permanente pharmacies and mail-order only*
Vision Benefits	Annual exam – Plan pays 100% (deductible waived). Hardware: $250 per calendar year maximum benefit. *No vision network required.*		Routine eye exam - $15 co-pay Prescription eyeglasses & contact lenses – balance after $150 credit every 24 months. *Kaiser Permanente vision providers only*

Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required. Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy.

Dental Plan Comparison 2016 - 2017			
Plan Name & Provider Network	**Pioneer Dental Any Licensed Dentist**	**Kaiser Dental Kaiser Provider**	**Willamette Dental Willamette Provider**
Monthly Employee Premium	Employee Only: $12.92 Employee + 1: $54.55 Family: $107.69	Employee Only: $15.35 Employee + 1: $62.73 Family: $103.16	Employee Only: $11.98 Employee + 1: $43.93 Family: $86.53
Annual Deductible	Individual - $50 Family - $150	None	None
Annual Maximum Benefit	$1,500 per person	$1,500 per person	None
Office Visits	None	$15 copay	$10 copay
Preventive Services *Exams, cleanings, x-rays, fluoride treatment*	Employee pays 0% (deductible waived)	Fully covered after office visit charge	Fully covered after office visit charge
Basic Services *Fillings, simple extractions*	Employee pays 20% after deductible	Fully covered after office visit charge	Fully covered after office visit charge
Major Services *Crowns, Bridges, Dentures*	Employee pays 50% after deductible	Employee pays 20% Coinsurance	Office visit charge plus: Crown $50 each, Bridge $50 per tooth, Dentures $100 each
Emergency Treatment	Employee pays 20% after deductible	$25 copay in-network Plan pays up to $100 for out-of-area emergency	$50 copay in-network Plan pays up to $100 for out-of-area emergency
Orthodontia *No age limit*	Employee pays 50% after deductible	Employee pays 50% up to $1,500; 100% thereafter	Pre-orthodontia visit $150, $1,200 treatment co-pay
Orthodontia Lifetime Maximum	$1,500	$1,500	None
Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required. Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy.			

Insurance Rate Changes



Your cost for coverage depends on the benefit elections you make and how many eligible dependents you enroll.

- Medical, dental, vision and FSA contributions are automatically deducted from your pay on a pre-tax basis.
- Life and LTD contributions are deducted from your pay on an after-tax basis.
- Employees with domestic partners should carefully read the information available through Human Resources regarding the IRS guidelines for premiums the College pays for domestic partner coverage.

When will the new rates appear on my paycheck?

- The new insurance premiums will appear on your March, 2016 paycheck.
- Flexible spending account deductions will begin on your April 2016 paycheck.

Monthly Medical & Dental Premium Rates Effective March 31, 2016

As you can see below Lewis & Clark pays a large percentage of the monthly medical and dental premiums costs for all medical and dental participants. This is in addition to the full premiums for the group Life and AD&D, Long-term Disability, Employee Assistance Plan (Cascade Centers), and 9% of each employee's base salary towards their retirement plan (TIAA-CREF).

	Total Premium	College Cost	Employee Cost
Pioneer Medical			
Employee Only	$678.10	$569.01	**$109.09**
Two Party	$1,356.41	$933.62	**$422.79**
Family	$1,892.93	$1,283.87	**$609.06**
Kaiser Medical			
Employee Only	$482.46	$408.44	**$74.02**
Two Party	$964.92	$678.15	**$286.77**
Family	$1350.89	$936.45	**$414.44**
Pioneer Dental			
Employee Only	$56.38	$43.46	**$12.92**
Two Party	$112.81	$58.26	**$54.55**
Family	$157.92	$50.23	**$107.69**
Kaiser Dental			
Employee Only	$58.60	$43.25	**$15.35**
Two Party	$117.21	$54.48	**$62.73**
Family	$164.08	$60.92	**$103.16**
Willamette Dental			
Employee Only	$40.70	$28.72	**$11.98**
Two Party	$81.40	$37.47	**$43.93**
Family	$122.45	$35.92	**$86.53**

Note: Employees with domestic partners should carefully read the information available through Human Resources regarding the IRS guidelines for premiums the College pays for domestic partner coverage.

Flexible Spending Accounts

A Flexible Spending Account enables you to increase your take-home pay by decreasing your taxable income. You can reduce the costs of insurance premiums, medical expenses not covered by insurance and dependent day care expenses by paying these costs on a *pre-tax* basis. The Plan Year for this benefit is April 1, 2016 through March 31, 2017. There are two Flexible Spending Accounts available: Health Care and Dependent Care.

1. The Health Care Spending Account allows you to pay for medical, dental, vision, and alternative care expenses with pre-taxed earnings by setting aside a specific monthly portion of your salary into the Allegiance Flex Advantage account for future use. When you incur an applicable expense, you can use your Benefits Debit Card at both healthcare and non-healthcare merchants or you can submit a simple claim form to Allegiance and they will mail you a check to reimburse the claim amount. The IRS requires an *annual re-enrollment* for the Health Care Spending account during the annual Open Enrollment period. The amount allowed this year is $2,550.

   Up to $500 unused funds can be rolled over and utilized for purchasing of authorized expenses. Any funds above and beyond $500 that is not used will be lost. All expenses must be made and claims for the 2015-16 benefits year must be submitted by June 30, 2016.

2. The Dependent Care Spending Account allows you to pay for dependent care expenses with pre-taxed earnings. By enrolling in the Dependent Care Spending account, you are instructing the College to set aside a specific monthly portion of your salary into the Allegiance Flex Advantage account for dependent care expenses. Please be advised that IRS regulations do not allow refunds for unused contributions; therefore this is a "use it or lose it" account. The IRS requires an *annual re-enrollment* for the Dependent Care spending account during the annual Open Enrollment period. The amount allowed this year remains at $5,000 per family. There is no rollover for Dependent Care Flexible Spending.

If your benefits debit card has expired or you want to apply for a Benefits Debit Card for the first time, please send in the Allegiance Debit Card application form on the Benefit Forms section of the Lewis & Clark Website and have the form in the HR office no later than Monday, March 7, 2016

If you wish to participate in a Flexible Spending Account in 2016, you must complete Workday Open Enrollment.

Other Lewis & Clark Benefits

Employee Assistance Program

Lewis & Clark College offers a short-term counseling and advising benefit designed to supplement coverage provided by medical insurance programs. This program is available to employees, their families, and significant others. The College has retained the services of Cascade Centers to provide individuals with no-cost private and confidential short-term counseling and referral to help them deal with the stresses and problems they may face in day-to-day life. Participants may receive up to four sessions, *for each issue or situation*, in a 12-month period. You may access immediate and confidential consultation 24 hours a day, seven days a week by calling 1-800-433-2320. You may also e-mail Cascade Centers at info@cascadecenters.com. Visit www.cascadecenters.com for more information.

Basic Life & Accidental Death and Dismemberment

A College paid group term life insurance plan through LifeMap is available for all regular employees who work at least 20 hours per week for 12 months per year, and faculty with .50 FTE. The college *contributes the entire cost* for the basic coverage for employees. This basic policy provides you with the security of life insurance and accidental death and dismemberment insurance coverage at 150% of your annual base salary. You can sign up for voluntary life/accidental death & dismemberment/buy-ups at any time of the year, but a health statement (EOI) will be required if you are past the first 31 days of hire.

Basic Long-Term Disability Coverage

Long-term disability insurance is available for all regular employees who work at least 20 hours per week for 12 months per year, and faculty with .50 FTE. Long-term disability insurance (LTD) replaces up to 60% of your pre-disability income if you are unable to work due to a disability. If you become disabled and are less than age 60, benefits are generally payable to age 65. If you become disabled after your 60th birthday, benefits are payable according to a schedule. The college *contributes the entire cost* for the basic coverage for employees. There is a 180-day waiting period for benefits on approved claims. Please see your certificate for complete details.

Short-Term Disability Coverage

Short-term disability coverage is available for all exempt (salaried) employees who work at least 30 hours per week for 12 months per year, and faculty with .75 FTE. Short-term disability payments are made by the college in the form of salary continuance. Benefits are payable beginning on the 23rd workday after the disability begins. All available sick time and vacation time will be included as part of the short-term disability payments.

TIAA-CREF Retirement Plans

- *How much does the College contribute towards my retirement?* ***9%*** of your monthly base salary with no employee match required. Even more amazing is that your retirement contributions are immediately fully vested. We are serious about our commitment to providing you with income during your retirement.

- *Who is eligible for the College's contribution?* You must be 21 years or older and a regular faculty or staff member (not adjunct, temporary, or student), who works at least 1000 hours or more per year.

- *When do I start receiving the College's contribution?* If you are a new employee, who did not come from another institution of higher education, the College will make its first contribution toward your Group Retirement Annuity (GRA) plan on the first day of the month following a year of service. For example, if your hire date is on September 8th, the College's retirement contributions will begin on October 1st of the following year. However, if you can prove that you have completed 12 months of service in which you worked at least 1,000 hours with another institution of higher education within 6 months of starting your employment with Lewis & Clark College and were not adjunct, temporary, or student status, you may be eligible to waive the one-year waiting period. A letter from your former employer is required to document employment.

- *When can I start contributing toward my retirement?* You can start contributing toward your retirement the first of the month following your hire date. All of our employees are welcome to participate, including our adjunct faculty and temporary employees. Starting in 2013, all new employees who are not adjunct or temporary are subject to a 3% auto-enrollment. There is a 90 day opt-out feature.

- *How do I make changes to my retirement contributions?* You can change your amount, start or stop your contribution at any time by going into Workday and edit your retirement under Change in All About Me / Benefits. *You are not limited to making changes during the "open enrollment" period.* Please keep in mind that your changes may be delayed by one month when changes are submitted in Workday after payroll has been run (it is best to make a change by the 15th of the month to be effective in the month the change is made.). Retirement change is not a required field during Open Enrollment, so if you want to make a change, please follow the above mentioned procedure.

Benefit Contact Sheet

The following table provides important phone numbers that you may need when enrolling for your benefits and throughout the year.

	Provider	Group or Policy Number	Phone	Hours
Medical, Vision, RX Insurance	PEHT/Regence	60026055	(866) 240.9580	7 am – 6 pm
	Kaiser	1495-001	(800) 813.2000	8 am – 6 pm
Dental Insurance	Willamette Dental	Z908A	(855) 433.6825	8 am – 5 pm
	PEHT/Regence	60026055	(866) 240.9580	7 am – 6 pm
	Kaiser	1495-006	(800) 813.2000	8 am – 6 pm
Retirement Savings	TIAA-CREF	GRA: 101700 GSRA: 101701	(800) 842.2776	5 am – 7 pm (M–F) 6 am – 3 pm (Sat)
Life Insurance and AD & D	LifeMap	OR300475	Contact HR x6234	8:30 am – 5 pm
Long Term Disability	LifeMap	OR300475	Contact HR x6234	8:30 am – 5 pm
Short Term Disability	Lewis & Clark	N/A	Contact HR x6234	8:30 am – 5 pm
Flexible Spending Account (FSA)	Allegiance	503711	(877) 424.3570	7 am – 5 pm
Employee Assistance Plan (EAP)	Cascade Centers	N/A	(800) 433.2320	always open

Important Legal Notices Affecting Your Health Plan Coverage

The Women's Health Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns Act Disclosure – Federal

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).

Notice of Special Enrollment Rights

If you are declining enrollment 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 this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

Notice of patient protections that require designation of a PCP

Kaiser HMO and POS group health plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Customer Service.

For children, you may designate a pediatrician as the primary care provider.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW or www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility –

OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov **Medicaid & CHIP Phone:** 1-877-314-5678	**Website:** http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm **Phone:** 1-800-562-3022 (toll free) ext 15473

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:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

If you have creditable coverage from another plan, you may be entitled to a reduction or elimination of exclusionary periods (if applicable) of coverage for preexisting conditions under your group health 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 COBRA continuation of coverage, when COBRA continuation of coverage ceases, if you request before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of prior creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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.

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

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent due to 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,

and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.