

**Summary Plan Description
for
Seattle Pacific University Group Health Plan**

Seattle Pacific University maintains a group welfare benefit plan to provide health and benefit coverage to eligible employees and their dependents. The group plan consists of several types of benefits: medical, dental, vision, group term life and accidental death and dismemberment insurance, and a flexible spending account. Each type of benefit has developed a plan brochure or certificate to describe the coverage available under the plan. These brochures/certificates do not contain all the information a federal law known as ERISA (Employee Retirement Income Security Act) requires for summary plan descriptions (SPDs). This “wraparound” SPD provides the missing information.

This wraparound SPD and certificate only describes the **Seattle Pacific University** Group Health Plan in a summary manner. The plan document(s) for the **Seattle Pacific University** Group Health Plan governs the plan(s) and includes more details on how it/they operates. If there is any conflict between (i) the wraparound SPD and certificate and (ii) the plan document, then the plan document will control. Participants and beneficiaries should not rely on any oral description of the plan because the written terms of the plan will always govern.

Plan Identification Information

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| Plan name: | Seattle Pacific University Group Health Plan |
| Plan number: | 507 |
| Type of plan: | The group health and benefit plans provide comprehensive medical, dental, vision, life/AD&D, disability, and flexible spending account benefits and is considered a “welfare benefit plan” under ERISA. |
| Type of funding: | The medical, dental, and flexible spending plans are self-insured and administered by Premera Blue Cross and Washington Dental Service, and Benefit Administration Company respectively. The Vision plan is fully insured by Vision Service Plan. The life/AD&D and disability are fully insured by the Standard Insurance Company. |
| Type of administration: | The fully-insured vendors provide claims administration and other services under the group insurance contract, self-insured benefits are not insured. |
| Claims administrator: | <p>Washington Dental Service P O Box 75983 Seattle WA 98175-0983 1-800-554-1907</p> <p>Premera Blue Cross 7001 220th St SW Mountlake Terrace, WA 98111-9159 1-800-722-1471</p> <p>Standard Insurance Company 900 SW Fifth Avenue Portland, Oregon 97204-1282</p> |

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| | (503)-321-7000 Benefit Administration Company (BAC) 1200 5 th Avenue, Suite 1100 Seattle, Washington 98101 (206) 625-1800 Vision Service Plan 3333 Quality Drive Rancho Cordova, California 95670 |
| Plan year: | The plan year begins on July 1 and ends on June 30 each year. The plan's financial records are based on the plan year. |
| Plan administrator: | Seattle Pacific University 3307 Third Avenue West, Suite 302 Seattle, WA 98119 (206) 281-2676 |
| Employer who sponsors the plan: | Seattle Pacific University 3307 Third Avenue West, Suite 302 Seattle, WA 98119 (206) 281-2676 |
| Employer's EIN (Employer Identification Number): | 91-0565553 |
| Agent for service of legal process: | Same as Plan Sponsor |
| Plan establishment: | Seattle Pacific University established the group health plan for the exclusive benefit of its eligible employees on July 1, 1970. |
| Wraparound SPD Revision Date | 7/01/2008. |

Coverage, Eligibility and Claims Procedures

Coverage. All claims for benefits under the plan are processed by each individual benefit provider under a group insurance contract. Each benefit provider has developed a brochure or certificate that describes the coverage under the plan. This wraparound SPD incorporates by reference each brochure/certificate. They are attached in the **Appendix**.

Eligibility:

Subscribers: All active, regular employees of Seattle Pacific University who regularly work a minimum nine (9) month work schedule and twenty (20) hours per week.

Retiree Subscribers: Retirees who were enrolled in the Group's medical and dental plans prior to termination of employment, may continue group medical and dental coverage as specified in the certificate.

Dependent: Shall mean any dependent as defined in IRC §152, as modified by IRC §105 and §106 and their accompanying regulations.

Claims procedures. You must file claims for benefits under the plan with the applicable individual benefit provider. The brochure/certificate describes the procedure for filing claims and the procedure for requesting a review of denied claims. As part of the claims administration process, each individual benefit provider will:

- pay claims for benefits due under the plan;
- provide written explanations of the reasons for denied claims;
- handle claimant requests for reviews of denied claims; and
- make the final decision on denied claims.

Under the Employee Retirement Income Security Act (ERISA) of 1974, you have the right to appeal a denied claim. Effective January 1, 2002, the claim review procedures will change for health care plans (including medical, dental, vision and health care flexible spending accounts).

See the following claims review charts:

| Claims Review Chart | | |
|---|--|--|
| Type of Claim | Steps to Take | |
| URGENT HEALTH CARE CLAIM | | |
| Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain. The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination. | Step 1: | The Plan has 72 hours after receiving your initial claim to approve or deny the claim. |
| | Step 2: | If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision. |
| | Step 3: | The Plan has 72 hours after receiving your appeal to notify you of its appeal decision. |
| | IF YOUR CLAIM IS IMPROPER OR INCOMPLETE | |
| | Step 1: | The Plan has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete. |
| | Step 2: | You have 48 hours after receiving notice from the Plan to correct or complete your claim. |
| | Step 3: | The Plan has 48 hours to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of: Receiving your completed claim, or Your deadline to complete the claim. |
| | Step 4: | If denied, you have 180 days after receiving the claim denial to appeal the Plan's decision. |
| PRE-SERVICE HEALTH CLAIM | | |
| Group health claims where treatment must be precertified before it is performed. | Step 1: | The Plan has 15 days after receiving your initial claim to notify you if your claim is approved or denied. |
| | Step 2: | You have 180 days after receiving the claim denial to appeal the Plan's decision. |

| Claims Review Chart | |
|---------------------|--|
| Type of Claim | Steps to Take |
| | Step 3: The Plan has 30 days after receiving your appeal to notify you of the appeal decision. If the Plan allows two levels of appeal, it has 15 days after receiving your appeal to notify you of its decision. Both levels of appeal must be completed within the 30-day deadline. |
| | IF YOUR CLAIM IS IMPROPER OR INCOMPLETE |
| | Step 1: The Plan has 5 days after receiving your initial claim to notify you that your claim is an improper claim. |
| | Step 2: The Plan has 15 days after receiving your claim to notify you of its decision to approve or deny the claim. If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision. (The time the plan waits for claimant information is not counted in totals.) |
| | Step 3: You have 45 days after receiving the extension notice to provide additional information or complete the claim. |
| | Step 4: If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision. |
| | Step 5: The Plan has 30 days after receiving your appeal (15 days if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 30-day deadline. |

| Claims Review Chart | |
|---|---|
| Type of Claim | Steps to Take |
| POST-SERVICE HEALTH CLAIM | |
| Group health claims where you request reimbursement after treatment has been performed. | Step 1: The Plan has 30 days after receiving your initial claim to notify you if your claim is denied. |
| | Step 2: If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision. |
| | Step 3: The Plan has 60 days after receiving your appeal (30 days if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline. |
| | IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION |
| | Step 1: The Plan has 30 days after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has 45 days after receiving the claim to notify you if your claim is denied. (The time the plan waits for claimant information is not counted in totals.) |
| | Step 2: You have 45 days after receiving the extension notice to provide additional information or complete your claim. |
| | Step 3: If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision. |
| | Step 4: The Plan has 60 days after receiving your appeal (30 days if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline. |

Claim Denials. If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination under the plan will:

- state the specific reasons for the determination;
- reference specific plan provisions on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court;
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- for urgent care claims, the denial notice will include a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

Appeals. If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days after receiving the claim denial to appeal the plan's decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the plan and you by telephone, fax, or other similar method.

If your appeal is denied, the denial notice will contain the following information:

- the specific reasons for the appeal determination;
- a reference to the specific plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all document, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about these procedures;
- a statement describing your right to bring a civil lawsuit under federal law;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- a statement that “You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”

The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Contributions and Funding

Employee contributions. Employees shall contribute toward the cost of the plan. Because **Seattle Pacific University** has adopted a Section 125 plan under the Internal Revenue Code (IRC), these contributions may be pretax employee contributions. The contribution amounts are specified in the plan documents and will be furnished to employees when they are hired and during the annual enrollment process.

Employer contributions. **Seattle Pacific University** shall contribute the difference between the cost of the plan and the amount the employees contribute.

Funding. The Vision and Life and Disability plans are unfunded and insured. **Seattle Pacific University** collects and sends the premiums to the individual benefit provider. The medical, dental and flexible spending accounts are unfunded and self-insured.

Role of Insurer. The plan’s benefits may be financed through a group insurance contract with each individual benefit provider. The benefit providers are responsible for investing the premiums and paying benefit claims. The benefit providers guarantee the payment of claims incurred before the group insurance contract terminates.

Role of Self-Insured Administrator. Although **Premera Blue Cross, Washington Dental Service and BAC** pay claims under the plan on behalf of **Seattle Pacific University**, they do not insure or guarantee that claims will be paid. Rather, they rely on **Seattle Pacific University** to provide them with money to pay the claims. They cannot pay the claims if **Seattle Pacific University** does not provide the money to them.

Plan Administration and Amendments

Named fiduciary and plan administrator. **Seattle Pacific University** is the named fiduciary and plan administrator authorized to control and manage the operation and administration of the plan. **Seattle Pacific University**, as named fiduciary, has allocated to each individual benefit provider responsibility for administering the plan’s claims procedures and for exercising other fiduciary functions described in the certificate.

Plan interpretations. In exercising their fiduciary functions, the plan fiduciaries have discretionary authority to determine eligibility for benefits and to interpret the terms of the plan. Using their discretionary authority, the plan fiduciaries may correct defects, make findings of fact, rectify any omission, or reconcile any inconsistency or ambiguity in the plan. This wraparound SPD does not constitute a contract of employment.

Plan amendments. Pursuant to the plan, **Seattle Pacific University** can amend or replace the group insurance contract through which benefit claims are paid under the plan. **Seattle Pacific University** also can amend the plan. **Seattle Pacific University's** decision to amend or replace the group insurance contract or to amend the plan is not a fiduciary decision that must be made solely in the interest of the employees, but is a business decision that can be made solely in **Seattle Pacific University's** interest. Plan amendments include amendments to terminate coverage for some or all employees. If the plan is terminated, the rights of a participant covered under the plan are limited to the payment of eligible expenses incurred prior to termination.

Rights Under Federal Law

Rights under HIPAA. The group health and benefit plans are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Special enrollment rights:

After declining coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 30 days after your other coverage ends.

New dependents. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you add coverage under these instances, the maximum length of any preexisting condition exclusion under this plan is 12 months. However, a preexisting condition exclusion does not apply to the pregnancy of you or, if applicable, your covered spouse, or to any newborn or adopted child who is added to the coverage within 30 days of the birth or adoption.

Preexisting conditions. A "preexisting condition" is a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on your enrollment date. Your "enrollment date" is the earlier of your first day of coverage under this plan or the first day of the waiting period before coverage begins. The maximum length of a preexisting condition exclusion under this plan is 12 months (or 18 months if you or your dependents sign up as late enrollees). A preexisting condition exclusion does not apply to the pregnancy of you or your covered spouse, or to any newborn or adopted child who is added to the coverage within 30 days of the birth or adoption.

Your prior coverage will count toward this plan's preexisting condition exclusion if you do not have a break in coverage between the old plan and this plan of 3 months. A waiting period under this plan does not count toward this 3 month period. In short, these rules make your health insurance coverage "portable."

You will need to present a copy of a health coverage certificate from your old plan in order to prove your prior coverage. If this plan is going to apply a preexisting condition exclusion to you or your covered dependents, you will be notified on this determination and your appeal rights.

Right to receive a certificate of health coverage. If your coverage under this plan stops, you and your covered dependents will receive a certificate that shows your period of coverage under the plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage under this plan.

Qualified medical child support orders. If a qualified medical child support court order (QMCSO) issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this plan;
- name and last known address of each child to be covered under this plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the plan administrator. Upon receipt, the plan administrator will notify you and describe the plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the plan. As a beneficiary covered under the plan, your child will be entitled to information that the plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Maternity coverage. 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 normal 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 physician, 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 hospital length of stay not in excess of 48 hours (or 96 hours).

Mastectomy coverage. Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Leave under Family Medical Leave Act (FMLA). If you take a leave of absence for your own serious health condition or to care for family member with a serious health condition or to care for newborn or adopted child, you may be able to continue your health coverage under the plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work, assuming you pay any contributions required for the coverage.

**COBRA coverage
(Applicable to medical, dental, vision and FSA benefits)**

Introduction

The following section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

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

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

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

When is COBRA 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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

COBRA Management Services, LLC
 P O Box 53525
 Bellevue, WA 98015
 (425) 452-9901 or toll-free (866) 517-7580

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months (not applicable to health FSA). When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months

after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months (not applicable to health FSA). There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Notice must be given to:

COBRA Management Services, LLC
P O Box 53525
Bellevue, WA 98015
(425) 452-9901 or toll-free (866) 517-7580

Second qualifying event extension of 18-month period of continuation coverage

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

If You Have Questions

Questions 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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Carrie McCrimmon
Seattle Pacific University
3307 Third Avenue West Ste. 302
Seattle, WA 98119-1957
(206) 281-2676

Mid-Year Changes Under Section 125 Plan. After the enrollment deadline has passed, you may make certain benefit changes during the year only if a change in status occurs (as outlined below). You must make the benefit change within 30 days of the change in status. Any change you make must be on account, and consistent with, the change in status.

Changes in status are:

- a change in your marital status (such as marriage, divorce, legal separation or annulment);
- a change in the number of your dependents for tax purposes (such as birth, legal adoption of your child, placement of a child with you for adoption, or death of a dependent);
- certain changes in employment status that affect benefits eligibility for you, your spouse or child(ren), such as: termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (for example, between full-time and part-time work, decrease or increase in hours);
- your child no longer meets the benefit plan's eligibility requirements;
- entitlement to Medicare or Medicaid (applies only to the person entitled to Medicare or Medicaid);
- change to comply with a state domestic relations order pertaining to coverage of your dependent child;
- your, your spouse's or child's eligibility for COBRA coverage;
- a change in your, your spouse's or child's place of residence;
- a significant increase in the cost of coverage or a significant reduction in the benefit coverage under your or your spouse's health care plan*;
- the addition, elimination, or significant curtailment of, a coverage option*;
- a change in your spouse's or child's coverage during another employer's annual enrollment period when the other plan has a different period of coverage*;
- a change in dependent care providers or costs, if the providers are not relatives of the employee (applies only for dependent care flexible spending accounts).

*These changes in status do not apply to a health care flexible spending account.

For details about benefit options, restrictions and administrative considerations that apply for specific status changes, see **Appendix 1** at the end of this SPD or contact the Plan Administrator.

Rights under ERISA. As a participant in **Seattle Pacific University's** Group Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants 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 such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, 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 administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

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

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 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 plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan 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 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.

Assistance with Your Questions

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

Acts of Third Parties (Subrogation). This provision applies whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury suffered by you or your dependent(s) that is covered by this plan. In that case, you must reimburse the plan for any benefits it paid relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized). The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining the compensation unless separately agreed to, in writing, by the plan administrator in the exercise of its sole discretion.

Medicare Election at Age 65. If you remain actively employed after reaching age 65, you or your spouse who is over age 65 may choose to remain covered under this plan without reduction for Medicare benefits or you may choose to designate Medicare as the primary payor of benefits. If you choose to remain covered under this plan, this plan will be the primary payor of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under this plan will end. If you do not specifically choose one of the options, this plan will continue to be primary. If you are under age 65 and your spouse is over age 65, your spouse can make his or her own choice.

Appendix 1

Mid-Year Changes Under Section 125 Plans

The benefit elections you make when you enroll in **Seattle Pacific University's** programs will be in effect for the entire plan year (or portion of the plan year that remains, if you are a new employee), unless you have a qualified mid-year event. You will *not* be able to change your coverages unless you file a written request for a change with your Human Resource Department within 30 days of any of the following mid-year events:

1. Change in Status. If one or more of the following Changes in Status occur, 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 (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the plan administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
- a change in the number of your dependents for tax purposes (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
- any of the following events that change the employment status of you, your spouse, or your dependent that affects benefit eligibility under a cafeteria plan (including this plan) or other employee benefit plan of yours, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching between salaried and hourly-paid, union and non-union, or part-time and full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit;
- a change in your, your spouse's, or your dependent's place of residence.

If a Change in Status occurs, you must inform the plan administrator and complete a payroll deduction form within 30 days of the occurrence. Your coverage change will be effective on the date you notify the plan administrator or as determined by the particular plan document. However, if your Change in Status is a birth, adoption, or placement for adoption of a Dependent child, coverage will be retroactively provided to the date of the event.¹

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The plan administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

¹ *Note:* An employer may always provide retroactive coverage to employees, but it cannot take retroactive pretax contributions (other than for a change in status as a result of birth, adoption or placement for adoption).

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and health care expense reimbursement benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your (a) divorce, annulment or legal separation from your spouse, (b) the death of your spouse or your dependent, or (c) your dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than (a) your spouse involved in the divorce, annulment, or legal separation, (b) your deceased spouse or dependent, or (c) your dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected spouse or dependent. However, if you, your spouse, or a dependent elect COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution to pay for such coverage.
- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

2. Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights.

3. Certain Judgments and Orders. If a judgment, decree or order, including a Qualified Medical Child Support Order (QMSCO), resulting from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this plan, you may change your election to provide coverage for the dependent child. If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

4. Entitlement to Medicare or Medicaid. If you, your spouse, or a dependent actually enroll in Medicare or Medicaid, you may cancel that person's health coverage. Similarly, if you, your spouse, or a dependent who has been enrolled in Medicare or Medicaid loses eligibility for same, you may, subject to the terms of the underlying plan, elect to begin or increase that person's health coverage.

5. Change in Cost. If the plan administrator notifies you that the cost of your coverage under the plan *significantly* increases during the plan year or there is a loss of coverage mid-year, you may choose either to make an increase in your contributions or revoke your election if there is no other plan option which

provides similar coverage. You may also revoke your election if there is a *significant* curtailment that amounts to a loss of coverage (e.g., a HMO ceases to be available) and there is no other plan option which provides similar coverage. However, if there is a *significant* curtailment that does not amount to a loss of coverage (e.g., an increase in deductibles or co-payments), you may not drop your coverage but only switch to a similar coverage. If the cost of coverage under the plan *significantly* decreases, all eligible employees, even those who previously did not participate in the cafeteria plan, may elect coverage under the plan. For *insignificant* increases or decreases in the cost of benefits, however, the plan administrator will automatically adjust your election contributions to reflect the minor change in cost. (This “Change in Cost” exception is not applicable to health care expense reimbursement accounts under the plan.)

6. Change in Coverage. If the plan administrator notifies you that your coverage under the plan is significantly curtailed you may revoke your election and elect coverage under another plan option which provides similar coverage. Also, if during the plan year the plan adds or eliminates a coverage option, you may elect the newly-added option or elect another plan option (when a plan option has been eliminated), and may do so on a pre-tax basis by making a corresponding election change under another plan option which provides similar coverage. Additionally, you may make an election change when there is a significant improvement in coverage provided under an existing benefit option. Further, you may make an election change that is on account of and corresponds with a change made under the plan of your spouse’s, former spouse’s, or dependent’s employer, so long as: (a) his or her employer’s plan permits its participants to make an election change permitted under the IRS regulations; or (b) this plan permits you to make an election for a period of coverage which is different from the period of coverage under his or her employer’s plan. (This “Change in Coverage” exception is not applicable to health care expense reimbursement accounts under the plan.)

Appendix 2

Copies of Benefit Plan Brochures/Certificates