



GONZAGA UNIVERSITY FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Administered by:

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GONZAGA UNIVERSITY FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

SECTION 1: INTRODUCTION

Gonzaga University is pleased to sponsor an employee benefit program known as a “Flexible Benefits Plan” for you and your fellow employees. It is so-called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. Gonzaga University provides you the opportunity to use pre-tax dollars to pay for them by entering into a salary reduction arrangement instead of using your after-tax pay. This helps you because the benefits you elect are nontaxable; you save social security and income taxes on the dollars in your salary reduction. Alternatively, you may choose to pay for any of the available benefits with after-tax contributions on a salary deduction basis.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between them and this booklet, the plan documents will apply.

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use funds provided through employee salary reduction, to choose one or more of the Benefit Plans or Policies offered through the Plan, and enable them to pay for the selected coverage(s) with pre-tax dollars.

Q-2. What benefits are provided by the Plan?

The Plan includes the following three component benefit plans:

- An Insurance Premium Payment component that permits an employee to pay for his or her share of health insurance premiums with pre-tax dollars;
- A Health Care Reimbursement component – also called a health flexible spending arrangement (health FSA) – that permits an employee to pay for his or her qualifying Health Care expenses (that are not otherwise reimbursable by insurance) with pre-tax dollars; and
- A Dependent Care Expense Reimbursement component (DCR) that permits an employee to pay for his or her qualifying dependent care expenses with pre-tax dollars.

Q-3. Who can participate in the Plan?

All regular employees of Gonzaga University who work 20 or more hours a week are eligible to participate in the Plan on the first day of the month following their date of employment. For faculty members whose contract is the first of the month, you are eligible to participate on that date. Regular employees who are on the University’s group medical plan, and do not otherwise meet the definition above, may participate in the Insurance Premium Plan only.

Those employees who actually participate in the Plan are called “Participants”. An employee continues to participate until the end of the Plan Year (January 1 through December 31) or he or she: i) elects not to participate in accordance with Q-7; ii) is no longer employed by Gonzaga University or iii) Continuation Coverage (as described below) is no longer in effect.

Q-4. What tax advantages are available through the Plan?

You save both Federal Income Tax and FICA (Social Security) taxes by participating. The following is an example of the tax savings you might experience as a result of participating in the Plan on a pre-tax basis.

Suppose your monthly gross pay is \$2,500 per month and your cost for coverage is \$140.00 per month. Also, suppose your total withholding (income tax and Social Security) is 22.65%. After paying for coverage from your after-tax pay, your take home pay is \$1,794.00. However, under the Insurance Premium Payment Plan, you will be considered to have received \$2,360.00 gross pay rather than \$2,500.00 for tax purposes with \$140.00 contributed for Health Care coverage. This means your take home pay will be \$1,825.00 with the Plan rather than \$1,794.00 without it. Thus, you save \$31.00 per month (\$372.00 per year) by participating in the Plan. The table below illustrates this savings:

	<u>With Flexible Benefits Plan</u>	<u>Without Flexible Benefits Plan</u>
Gross Monthly Pay	\$2,500	\$2,500
Pre-Tax Coverage Under Plan	140	--
Taxable Income	<u>2,360</u>	<u>2,500</u>
Estimated Federal Tax (15%)	354	375
FICA Tax	181	191
After-Tax Coverage	<u>--</u>	<u>140</u>
Take Home Pay	\$1,825	\$1,794

Q-5. How do I become a participant?

You become a Participant by signing an individual Salary Reduction Agreement on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You will be provided with a Salary Reduction Agreement when you first become eligible to participate. You must complete the form and turn it in to the Human Resource Manager within the time period specified by the Plan Administrator. If you do not elect coverage when you are first eligible, you will have to wait until the next Open Enrollment Period to enroll for the following Plan Year or until such time that you have a Change in Status, as described in Q7.

In future years, a new Salary Reduction Agreement will be made available to you during each Open Enrollment Period, and you will be given the opportunity during Open Enrollment to elect your coverage for the 12 months covering the next January 1 through December 31. This 12-month period is called the “Plan Year.”

A Participant who fails to complete, sign and file a Salary Reduction Agreement shall be deemed to have elected to continue participation in the Premium Payment component with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease

in applicable premiums), and (except for a Change in Status) will not be permitted to modify his election until the next Open Enrollment Period. A participant who fails to complete, sign and file (or file in a timely manner) a Salary Reduction Agreement for the annual elections to participate in the Health Care and Dependent Care Expense Account Plans prior to the beginning of each Plan Year, will not be reenrolled, and must wait to participate until the next Open Enrollment Period, or until there is a qualifying Change in Status.

Q-6. What is the Open Enrollment period?

The Open Enrollment period will generally begin at least 30 days before the beginning of the Plan Year.

Q-7. Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the salary reduction amounts you have selected during the Plan Year, although your election will terminate if you are no longer working for Gonzaga University.

There are several important exceptions to this general rule: You may change or revoke your previous elections if you have a “change in status” which affects your eligibility as described below.

1. Change in Status. If one or more of the following Changes in Status occurs and the change affects you and/or your dependent’s eligibility for plan benefits, you may revoke your old election and make a new election, either increasing or decreasing coverage. Both the revocation and the new election must be caused by and are consistent with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below and any other events that the Plan Administrator (in its sole discretion) determines to be within prevailing IRS guidance:

- a change in your legal marital status (such as marriage, divorce, legal separation, annulment or death of your spouse);
- a change in the number of your dependents (such as birth or adoption of a child or placement of a child for adoption, or the death of a dependent);
- termination or commencement of employment by you, your spouse, or your dependent;
- a change in your, your spouse’s or your dependent’s work hours (including switch between full and part-time status);
- your dependent’s satisfying or ceasing to satisfy an eligibility requirement for a particular benefit; such as age or student status; and
- a change in your, your spouse’s or your dependent’s place of residence or work.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election form within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and is consistent with a change in status and subsequent change in eligibility. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and is consistent with a Change in Status.

- 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 under the Premium Payment component under the Plan, but not the Health Care Reimbursement or the Dependent Care Expense Reimbursement (DCR) components of the Plan. 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 from a divorce, separation, annulment or custody change requires your child to be covered under this Plan or your former spouse's plan, if the Order requires you to cover the child, you may change your election to provide coverage for the child. If the Order requires that your former spouse cover the child, you may change coverage for the child under the Premium Payment and Health Care Reimbursement components of the Plan, but not the Dependent Care Expense Reimbursement (DCR) component.
- 4. Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may change coverage for that person's coverage under the Premium Payment component and Health Care Reimbursement components of the Plan, but not the Dependent Care Expense Reimbursement (DCR) component.
- 5. Significant Changes in Cost or Coverage.** If an independent, third-party provider of medical benefits significantly increases premiums or significantly curtails coverage, you may revoke your election under the Premium Payment component and elect coverage under another health option with similar coverage, provided that you notify the Plan Administrator within 30 days of receiving written notice of the change. Under the Dependent Care Expense Reimbursement (DCR) component, if a dependent care provider increases the monthly fee, you may increase your election accordingly to reflect the new fee. No election changes are allowed if the dependent care provider is your relative. No changes under the Health Care Reimbursement component are allowed for Significant Changes in Cost or Coverage.
- 6. Changes in Coverage Attributable to Spouse's Employment.** If there is a significant change in your or your Spouse's health coverage that is attributable to your Spouse's employment, you may change your election under the Premium Payment and Dependent Care Expense Reimbursement (DCR) components of the Plan provided that the change is consistent with the change in coverage. No changes under the Health Care Reimbursement component are allowed.

To make a change, you must file a written request for change with the Plan Administrator within 30 days of the event permitting the change.

Additionally, the Plan Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law and adjustments may also be made to reflect insignificant mid-year premium increases imposed by third party insurers.

Q-8. How are my Premium Payments made?

When you become a participant, your premiums will be paid with that portion of gross income that you have elected to forego through pre-tax salary reductions.

Q-9. What if I terminate my employment during the Plan Year?

If your employment with Gonzaga University is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See Q/A –13 of this summary and the health insurance booklets for information on your right to continued or converted group health coverage after termination of your employment. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections shall remain in effect for the remainder of the Plan Year.

Q-10. Will I have any administrative costs under the Plan?

Gonzaga University is currently bearing the entire cost of administering the Plan.

Q-11. How long will the Plan remain in effect?

Although Gonzaga University expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-12. What happens if a claim for benefits is denied?

If your claim is for a benefit under the health insurance plan, you will generally proceed under the claims procedure applicable under that plan or policy. However, if you are denied a benefit under this Plan due to an issue germane to your coverage under this Plan, the claims procedure under this Plan will apply, and you will be notified in writing by the Plan's administrator within 30 days (or 45 days with written extension) of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied and will further advise you of what steps, if any, you might take in order to validate the claim.

Notification of a denied claim will be sent out:

- A specific reason or reasons for the denial;
- The specific Plan provision on which the denial is based;
- A description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- Appropriate information of the steps to be take if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documentation and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

It will advise you of your right to request an administrative review of the denial of the claim (you may request a review any time within the 180-day period after you have received notice that the claim was denied). You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for review. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- A specific reason or reasons for the decision on review;
- The specific Plan provision on which the decision is based;
- A statement of your right to review (upon request and at no charge) relevant documentation and other information;
- If an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, a description of the specific rule information, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- A statement of your right to file suit under ERISA Section 502(a) (where applicable).

Q-13. What is “Continuation Coverage” and how does it work?

This is your notice of CONTINUATION COVERAGE RIGHTS UNDER COBRA for yourself, your spouse and your dependents.

You are receiving this notice in the SPD because you have recently become covered under the Gonzaga University Flexible Benefits Plan. This 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 and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan’s Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator or from third party administrators: Rehn & Associates, PO Box 5433, Spokane, WA, 99205, (509) 534-0600 or 800-872-8979. The Plan Administrator is responsible for administering COBRA continuation coverage.

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" and you have a positive balance in the Health Care Reimbursement component of your Flexible Benefits Plan. Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. 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 will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) 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 will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) You become divorced or legally separated from your spouse.

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

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parents become divorced or legally separated; or
- (5) The child stops being eligible for coverage under the plan as a "dependent child".

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, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these 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. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Rehn & Associates.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts until the end of the current Plan Year.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Rehn & Associates or you may contact the nearest Regional or District Office of the U.S. Department of

Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

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.

Q-14. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g. pension, disability and life insurance), which are based on taxable compensation.

Q-15. What is the Family and Medical Leave Act?

Under the Family and Medical Leave Act (FMLA), if you are on eligible leave, then you may continue to pay for your health insurance coverage on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis via extra salary reductions before you go on leave). If your employer pays a portion of your health insurance premiums, then it must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of the health insurance premiums. You should be provided with a complete explanation of your FMLA rights and responsibilities.

SECTION II: INSURANCE PREMIUM PAYMENT BENEFIT

Q-16. What are "Premium Payment Benefits"?

Under the Plan you can elect specific insurances (medical, dental, etc.) as described in Q-2. We call these insurance benefits "Premium Payment Benefits". You receive your insurance coverage through the respective insurance companies. Your Employer will not be liable to you if an insurance company fails to pay for any of the insured benefits.

Q-17. How are my Premium Payment Benefits paid?

If a Participant elects the pre-tax option, the Participant's share (as determined by the Employer) of the premium for the Health Insurance Plan benefits he elects will be financed by Salary Reductions. Salary Reductions are applied by the Employer to pay for the Participant's share of the premium, and, for the purpose of this Plan and for Code compliance; such Salary Reductions are considered Employer contributions. The Employer will pay under this Plan its share of the premium for Participants who elect to participate in the pre-tax feature of this Plan. For those who elect the after-tax option, the employee portion of the premium will be paid outside of this Plan.

SECTION III: HEALTH CARE EXPENSES REIMBURSEMENT ACCOUNTS

Q-18. What are Health Care Expense Reimbursement Benefits?

Under the Health Care Reimbursement component, you purchase a specific level of Health Care Reimbursement benefits, paying for coverage through the Salary Reduction Agreement with Gonzaga University, in lieu of a corresponding amount of current pay, which means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the Plan for certain eligible Health Care Expenses. This arrangement helps you because the level of coverage you elect is non-taxable, thereby saving you social security and income taxes on the amount of your salary reduction.

Q-19. What is my “Health Care Expense Reimbursement Account”?

If you elect benefits under this portion of the Plan, a Health Care Expense Reimbursement Account will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year. Your Health Care Reimbursement Account is merely a record keeping account; it is not funded (all reimbursements are paid from the general assets of Gonzaga University).

Health Care Expense Reimbursement Accounts are intended to pay benefits solely for Health Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health Care Expense Reimbursement Account shall not be considered to be a group health plan for coordination of benefits purposes, and Health Care Expense Reimbursement Accounts shall not be taken into account when determining benefits payable under any other plan.

Q-20. What annual benefits are available under the Health Care Reimbursement component, and how much will they cost?

You may choose any amount of Plan Year reimbursement you desire, subject to a maximum reimbursement amount of \$5,000 maximum per year and a minimum of \$10/month or \$120/year. You will be required to pay the annual premium equal to the coverage level you have chosen.

Q-21. How is my Health Care Expense Reimbursement benefit paid for?

When you complete the Salary Reduction Agreement, you specify the amount of Health Care Reimbursement you wish to pay with your salary reduction. Thereafter, you must pay a premium for such coverage by having an equal portion of the annual premium deducted from each paycheck. The full amount of the coverage you have elected will be available to reimburse you for certain Health Care Expenses at any time during the Plan Year, so long as you continue to pay the premiums.

Q-22. What amounts will be available for Health Care Expense Reimbursement at any particular time during the Plan Year or subsequent Grace Period?

Provided that you have continued to pay the periodic premiums due for this benefit, then the full annual amount of coverage that you have elected will be available at any time during the Plan Year or grace period, although reduced by the amount of prior reimbursements received during

the Year. The Grace Period is the 2 ½ months immediately following the end of the Plan Year in which you may continue to incur claims. The Grace Period ends March 15 of each year.

Q-23. How do I receive reimbursement under the Plan?

If you elect to participate in this Plan, then you will have to take certain steps to be reimbursed for your Health Care Expenses. When you incur an expense that is eligible for payment, you must submit a claim to the Plan’s contract administrator, A. W. Rehn & Associates, Inc. on a claim form that will be supplied to you. You must include written statement(s) from an independent third party(ies) stating that the Health Care expense(s) have been incurred, and the amount of such expense(s) along with the claim form. In addition, you must include an Explanation of Benefits (EOB) Form(s) from any primary Health Care and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay. Claims should be submitted to:

Rehn & Associates
P.O. Box 5433
Spokane, WA 99205
(509) 534-0600

Claims are paid on a daily or weekly basis through the contract administrator, depending on the selection made by the Plan Administrator. Remember, though, you cannot be reimbursed for any total expenses above the annual reimbursement amount you have elected.

You have 90 days from the end of the Plan Year in which to submit a claim for reimbursement for Health Care Expenses incurred during the previous Plan Year or subsequent grace period. This “run out” period ends March 31 of each year. You will be notified in writing if any claim for benefits is denied.

Please note that it is *not necessary* for you to have actually paid the bill for a Health Care Expense – only for you to have *incurred* the expense and that it is not being paid for or reimbursed from any other source.

Q-24. What is a “Health Care Expense”?

A “Health Care Expense” generally means an item for which you could have claimed a Health Care Expense deduction on an itemized federal income tax return (see IRS Publication 502, Section 213(d) for which you have not otherwise been reimbursed from insurance or from some other source. Health Care Expenses are limited to generally recognized health care expenses, which are defined to mean (a) expenses incurred for diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body, and (b) for transportation primarily for and essential to such Health Care and dental care. They include, for example, expenses you, your spouse or eligible dependents have incurred for:

- Medicine, drugs, birth control pills and vaccines that your doctor prescribed.
- Over the counter drugs and medicines.
- Medical doctors, dentists, eye doctors, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists, chiropodists, Christian Science practitioners and naturopaths.
- Medical examination, x-ray and laboratory service.
- Nursing care services.
- Hospital care (including meals and lodging), clinic costs and lab fees.

- Medical treatment at a center for drug and alcohol addiction.
- Medical aids such as hearing aids (including batteries), dentures, eyeglasses, contact lenses, braces, artificial limbs, orthopedic shoes, elastic hose as medically prescribed, crutches, wheelchairs, guide dogs and the cost of maintaining them.
- Ambulance service and other travel costs to get medical care. If you use your own car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim \$.15 a mile. Add parking and tolls to the amounts you claim under either method.
- Stop smoking programs (but not non prescription drugs to aid in smoking cessation)
- Weight loss programs prescribed by a physician in treatment of a specific medical condition. Special foods and over the counter drugs are not covered.
- Automobile modifications (hand controls, special equipment, mechanical lifts)
- Eye surgery to correct vision
- Vasectomy
- Tubal ligation
- Any other Section 213(d) expenses as revised by the IRS

However, the following items are not Health Care Expenses, even if they meet the criteria of IRS Publication 502:

EXCLUSIONS

- Health insurance premiums that you or your spouse pay for coverage under another health plan;
- Basic cost of Medicare Insurance, life insurance or income protection policies;
- Long-term care services;
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease;
- The salary expense of a nurse to care for a healthy newborn at home;
- Household and domestic help (even though recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework);
- Custodial care;
- Health club dues, or fitness programs;
- Social activities, such as dance lessons (even though recommended by a qualified physician for general health improvement);
- Bottled water;
- Maternity clothes;
- Diaper service or diapers;
- Cosmetics, toiletries, toothpaste, etc.;
- Vitamins, food supplements or special foods, even if prescribed;
- Marijuana and other controlled substances, even if prescribed;
- Funeral and Burial Expenses;
- Massage therapy, unless necessary due to a medical condition;
- Home or Automobile improvements;

- Transportation expenses of any sort;
- Automobile insurance;
- Any item that doesn't constitute "medical care" under Code Section 213; and
- Any item that isn't reimbursable under applicable regulations.

ORTHODONTIC TREATMENT

Expenses for orthodontic treatment can only be reimbursed for the expenses incurred during the Plan Year or subsequent grace period. The Plan will reimburse up to one third of the entire cost of the orthodontic treatment when the braces are installed and amortize the remaining amount of the cost over the treatment period.

Q-25. When must the expenses be incurred?

Health Care Expenses must have been incurred during the Plan Year or subsequent grace period. You may not be reimbursed for any expenses arising before the Plan became effective, before your Salary Reduction Agreement became effective, for any expenses incurred after the close of the grace period, or after a separation from service (except for Continuation Coverage).

Q-26. What if the Health Care Expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Health Care expenses you have incurred and the annual coverage level you have elected and paid for. Any unused annual coverage benefit not used before the end of the grace period shall be forfeited and used to offset administrative expenses and future costs.

Q-27. Will I be taxed on the Health Care Reimbursement benefits that I receive?

You will not normally be taxed on your Health Care Reimbursement benefits, up to the limits set out in Q-20 of this summary. However, the Employer cannot guarantee that specific tax consequences will flow from your participation on the Plan. The tax benefits that you receive depend on the validity of the claims you submit.

SECTION IV: DEPENDENT CARE EXPENSES REIMBURSEMENT ACCOUNTS

Q-28. What are Dependent Care Expense Reimbursement Benefits?

Under the Dependent Care Expense Reimbursement (DCR) component, you provide a source of pre-tax funds to reimburse yourself for your Eligible Dependent Care Expenses by entering into a Salary Reduction Agreement with Gonzaga University under which you agree to a salary reduction to fund Dependent Care Expenses in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is non-taxable, thereby saving you social security and income taxes on the amount of salary conversion.

Q-29. What is my "Dependent Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a Dependent Care Expense Reimbursement Account will be set up in your name to keep a record of the reimbursements you are entitled to. Your Dependent Care Reimbursement Account is merely a record keeping account; it is not funded (all reimbursements are paid out of the general assets of Gonzaga University).

Q-30. What is the maximum Dependent Care Reimbursement benefit I may elect?

This amount can not exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently \$5,000 per Plan Year if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those dependents for whom you are eligible to receive tax-free reimbursements under the DCR, your spouse maintains a separate residence for the last six months of the calendar year, and you file a separate tax return; or
- are single or are the head of the household for tax purposes.

If you are married and reside with your spouse, but you file a separate federal income tax return, then the maximum DCR benefit you may elect is \$2,500.

Q-31. How is my Dependent Care Expense benefit funded?

When you complete the Salary Reduction Agreement, you specify the amount of DCR benefits for which you wish to pay with your salary reduction. Thereafter, your Dependent Care Reimbursement Account will be credited with the portion of your gross income that you have elected to forego through salary reduction. These portions will be credited as of each pay period. The amount that is available for reimbursement at any particular time will be whatever has been credited to your Dependent Care Reimbursement Account, less any reimbursements already paid.

Q-32. What is a “Dependent Care Expense” for which I can claim a reimbursement?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under the age of 13, who resides with you and whom you could claim as a dependent on your federal income tax return; any other dependent who is mentally or physically incapable of self-care; or your spouse, if the spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet *all* of the following conditions for them to be eligible Dependent Care Expenses:

1. the expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies;
2. each individual for whom you incur the expenses is:
 - (a) a dependent under age 13 whom you are entitled to a personal tax exemption as a dependent; or
 - (b) a “qualifying relative” is someone who is not a “qualifying child,” as defined above, but who meets
 - (1) specified relationship requirements (i.e., is a child, brother/sister, father/mother, etc) set forth in the Code;
 - (2) a support test (i.e., the taxpayer provides over one-half of the individual’s

- support); and
(3) a gross income limitation (no more than \$3,100 for 2004). the expenses are incurred for the care of a dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed;
3. if the expenses are incurred for services outside your household and such expenses are incurred for the care of a spouse or other tax dependent age 13 or older who is incapable of self-care, such individual regularly spends at least eight hours per day in your home;
 4. if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations;
 5. the expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent; and
 6. this reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:
 - (a) \$5,000;
 - (b) \$2,500, if you are married but you and your spouse file separate tax returns;
 - (c) your taxable compensation (after your Salary Reduction under this Plan); and
 - (d) if you are married, your spouse's actual or deemed Earned Income.
 7. expenses are not paid for services outside your household at a camp where the dependent stays overnight.

For purposes of (d) above, your spouse will be deemed to have Earned Income of \$200 (\$400 if you have two or more dependents described in paragraph 2 above), for each month in which your spouse is (i) physically or mentally incapable of self-care, or (ii) a full-time student at an educational institution.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense, if you have any doubts.

Q-33. How do I receive a Dependent Care Expense Reimbursement under the Plan?

If you have elected to participate in this portion of the Plan, you will have to take certain steps in order to be reimbursed for your Dependent Care Expenses. When you incur an expense that is eligible for payment, you must submit a claim to the contract administrator, A. W. Rehn & Associates, Inc. on a claim form that will be supplied to you. Your claim must include a statement from the dependent care provider showing the dates the expenses were incurred, the name of the dependent cared for, the cost of the care and the provider's taxpayer identification number. If there are enough credits in your Dependent Care Expense Reimbursement Account, you will be reimbursed for your eligible expenses. Please read the claims instructions with which you have been furnished and sent claims to:

Rehn & Associates
P.O. Box 5433
Spokane, WA 99205
(509) 534-0600

If a claim is for an amount that is more than your current Dependent Care Reimbursement Account balance, then the excess part of the claim will be carried over into the next payment cycle, to be paid out as your balance becomes adequate. Remember, though, that you can not be reimbursed for any total expenses above the available annual credits to your Dependent Care Reimbursement Account. You may not be reimbursed for any expenses that arise before your Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year.

Please note that it is not necessary for you to have actually paid an amount due for Dependent Care Expenses – only for you to have incurred the expense, and that it is not being paid for or reimbursed from any other source.

You will have 90 days after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

Q-34. What if the Dependent Care Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Dependent Care Expenses you have incurred and the annual coverage level you have elected and paid for. Any unused annual coverage benefit not used shall be forfeited and used to offset administrative expenses and future costs.

Q-35. Will I be taxed on the DCR benefits I receive?

You will not normally be taxed on your DCR benefits, up to the limits set out in Q-29 of this summary. However, to qualify for tax-free treatment, you will be required to file IRS Form 2441 or a similar form with your annual income tax return to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed tax-free reimbursement.

Q-36. If I participate in the DCR, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your Dependent Care Expenses may be eligible for the dependent care credit.

Q-37. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual dependent care expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only \$3,000 such expenses for one dependent, or \$6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of \$1,050 for one dependent or \$2,100 for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of \$600 for one dependent or \$1,200 for two or more dependents). The maximum 35% rate must be

reduced by 1% (but not below 20%) for each \$2,000 portion (or any fraction of \$2,000) of your adjusted gross income over \$15,000.

Q-38. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in one of the lower income tax brackets, you might come out ahead by including the DCR benefits in income and by claiming the credits for dependent care and earned income. On the other hand, it will generally be better to treat DCR benefits as tax-free the more income taxes you are required to pay. Because the actual determination of the preferable method for treating benefit payments depends on a number factors such as one's tax filing status (e.g. married, single, head of household), number of dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits. Use IRS Form 2441 to help you.

**SECTION V:
ERISA**

Q-39. What are my ERISA Rights?

The Flexible Benefits Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act (ERISA). However, Plans with 100 or more participants in the Health Care Reimbursement Accounts may be governed by ERISA. As a participant in an ERISA-covered benefit, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies); and
- receive a summary of the Plan's annual financial report (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

COBRA AND HIPAA Rights. You have a right to continue your Health Insurance Plan (here, major medical insurance) coverage (and, in some instances, your Health FSA coverage) for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Please review Q-13 of this SPD and the documents governing the plan on the rules of 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 credible 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 credible 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.

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 the 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 benefit from the plan, or from exercising your rights under ERISA.

If your claim for a benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and have the Plan Administrator reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in 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 that is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this Part of the Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the U.S. Department of Labor, Employee Security Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Security Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W. Washington, D.C. 20210.

Q-40. What other General Information should I know?

This section contains certain information that you may need to know about the Plan.

A. General Plan Information

- The Name of the Plan is Gonzaga University Flexible Benefits Plan
- The Plan Number assigned to your Plan is 506
- The provisions of the Plan described herein became effective on January 1, 1993.
- Your Plan’s records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan year is January 1 through December 31.
- This is a welfare plan. Therefore, your benefits are not insured by the Pension Benefit Guaranty Corporation (PBGC), an agency of the federal government. The PBGC generally requires or provides insurance for certain pension plans only.

B. Employer Information

Gonzaga University
502 E. Boone
Spokane, Washington 99212
Employer ID: 91-0236600

C. Plan Administrator Information

The name, address and business telephone number of your Plan Administrator are:

Benefits Office
Gonzaga University
502 E. Boone
Spokane, Washington 99212
(509) 323-5997

The Plan is administered by Gonzaga University with the assistance of a contract administrator, A. W. Rehn & Associates, Inc.

The Plan Administrator is designated as agent for all purposes of legal process.