

**FLEXIBLE SPENDING ACCOUNT  
PLAN INFORMATION SHEET**

Employer Name	<b>Willamette University</b>
Employer Address	<b>900 State Street Salem, OR 97301</b>
Payroll Contact	<b>Linda Gerlits</b>
Employer Federal ID Number	<b>93-0386972</b>
Plan Number	<b>501</b>
Plan Administrator	<b>Willamette University</b>

<b>"PERIOD OF COVERAGE"</b> of this Plan:	<b>4-1-08</b>	Through	<b>3-31-09</b>
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**"WAITING PERIOD"** - You will be required to satisfy waiting periods before becoming eligible to participate. The employee shall be eligible to participate in the Health or Health-Related Insurance Premium, the Dependent Care and the Health Related Expense program after the eligibility requirement has been satisfied. The employee must be regularly scheduled to work at least 1248 hours per year and be a continuing staff or faculty member with expected employment continuing through at least the end of the plan year.

**UNINSURED HEALTH EXPENSE REIMBURSEMENT PROGRAM:**

**MAXIMUM EMPLOYEE CONTRIBUTION** participants can make to the participant's account under the Uninsured Health Expense Reimbursement Program is:

<b>\$5,000.00</b>	per Plan Year (pro-rated for less than a full year).
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**DEPENDENT CARE EXPENSE REIMBURSEMENT PROGRAM:**

**MAXIMUM EMPLOYEE CONTRIBUTION** participants can make to the participant's account under the Dependent Care Expense Reimbursement Program is:

<b>\$ 5,000.00</b>	per Plan Year (legal maximum of \$5,000; \$2,500 for a married individual filing a separate return).
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**PARTICIPATION ENDS:** Your participation in the Uninsured Health Expense Reimbursement Program will end on the last day of the pay period in which you terminate employment unless you elect to participate through COBRA.

**"RUN OUT PERIOD"** is   90   days after the close of the Plan Year.

**BENEFIT PROGRAMS:**

- a. **Group Health Insurance Premium Benefit:** If you elect this program, your salary reductions will be used to pay the premium for medical and Hospitalization insurance, major medical insurance, dental insurance, and/or insurance for you and your eligible family members.
  
- b. **Unreimbursed Eligible Health-Related Expense Reimbursement:** If you select this program, your salary reductions will be deposited into an account from which funds will be withdrawn to reimburse you for eligible uninsured medical expenses incurred by you and your eligible family members.

- c. **Dependent Care Reimbursement:** If you elect this program, your salary reductions will be deposited into an account from which funds will be withdrawn to reimburse you for qualified dependent care expenses.

**EMPLOYER CONTRIBUTION** to the participant's account under the Uninsured Health Expense Reimbursement Program is:

\$100.00 per month under the following conditions:

The employee is eligible for this employer paid Unreimbursed Health Related Expense Account per month *only if they opt out of the employer sponsored health plan.*

### **STATUS CHANGES:**

Election Changes are those made effective by the IRS January 1, 2001. Any new election must be made and communicated in writing to the Administrator and the Administrator's Representative within **30 days** of the Change in Status. If you have a question as to whether a change is allowable, please see your Plan Administrator. Only expenses incurred on or after your change effective date and prior to the end of the plan year are eligible for payment under the plan. An eligible expense is one incurred on the date a service is provided or rendered and not on the date that the service is billed or paid. Participants in the Health Expense Account shall be allowed to increase the annual election in connection with a qualified Change in Status due to loss of spouse's health coverage (as described in Section 4.6 of the Plan).

Participants who, due to change in spouse's health coverage, elect to participate in the Willamette University Health Plan will no longer be eligible for the ***Employer paid*** Unreimbursed Health Related Expense contribution of \$100.00 per month, as they will no longer be opting out of the employer sponsored health plan.

### **CONTINUATION COVERAGE FOR MEDICAL COVERAGE:**

Federal law requires most employers sponsoring a group health plan to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law.

As an employee covered by the Medical Reimbursement Plan, you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or because you terminate your employment (for reasons other than gross misconduct on your part).

If you are the spouse or dependent of an employee covered by these plans you also have certain rights under COBRA.