

**Northwestern Health Sciences University**

**Cafeteria Plan**

**SUMMARY PLAN DESCRIPTION**

Effective January 1, 1994

Amended and Restated Effective January 1, 2005

# Northwestern Health Sciences University Cafeteria Plan

## SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to explain the Northwestern Health Sciences University Cafeteria Plan in a manner that you can easily understand. If you have any questions after reading this Summary Plan Description, please call the Human Resources Department at (952) 888-4777.

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## **THE PURPOSE OF THE PLAN**

Northwestern Health Sciences University has established this Plan to make available to Eligible Employees different combinations of health care benefits, dental care benefits, dependent care benefits and direct compensation.

## **DEFINITIONS**

Here are some definitions that will help you better understand this summary of the Plan:

1. **COMPANY** – Northwestern Health Sciences University.
2. **DEPENDENT** - A person whom you can claim as a dependent on your federal income tax return. In general, a person will qualify as your Dependent for a year if you provide more than one-half (1/2) of his or her support during the year and certain other tests are met. Your Dependents will usually include your children who were under the age of nineteen (19) at the end of the year or who were full-time students at a school for at least five (5) months during the year. Your Dependents may also include other persons who are either related to you by blood or marriage or lived in your home as a member of your household during the entire year if they had less than the gross income exemption amount allowable under the code (does not apply to group health plans) during the year (excluding nontaxable amounts such as social security or welfare benefits). The instructions to your federal income tax return discuss in some detail who qualifies as your Dependent.
3. **ELIGIBLE EMPLOYEE** - An employee of the Company, who is employed in the United States and who is eligible for the Company-sponsored health and/or dental plan(s).
4. **PAYMENT AND HEALTH CARE OPERATIONS** - Payment is considered to be activities undertaken by the plan sponsor to obtain premiums or determine or fulfill its responsibility for coverage and provisions of plan benefits that relate to an individual to whom health care is provided. Payment activities include, but are not limited to, the following:
  - i. Eligibility determinations, coverage and cost determinations including co-pays, plan maximums, and sharing of premium amounts;
  - ii. Coordination of benefits determinations;
  - iii. Adjudication of health benefits claims including appeals and other payment disputes;
  - iv. Establishing employee contributions;
  - v. Subrogation of health benefit claims;
  - vi. Billing and collection activities related to health care data processing;

- vii. Obtaining payment under a contract for reinsurance including stop-loss and excess of loss insurance;
- viii. Claims management and related health care data processing including auditing payments, investigating and resolving payment disputes, and responding to participant inquires regarding payment;
- ix. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- x. Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
- xi. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement. The following protected health information (PHI) may be disclosed for payment purposes: date of birth, Social Security Number (except where prohibited by state law), payment history, account number and name, and address of the health care provider or health plan;
- xii. Reimbursement to the plan.

Health care operations include, but are not limited to the following:

- i. Quality assessment;
- ii. Population-based activities relating to improving health care or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- iii. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- iv. Underwriting, premium rating and other activities related to the creations, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims including stop-loss insurance and excess of loss insurance;
- v. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- vi. Business planning and development, such as conducting cost-management and planning-related analyses related to management and operating the plan, including formulary development and administration, development or improvement of payment or coverage policies;
- vii. Business management and general administrative activities of the plan, including, but not limited to:
  - a. Management activities relating to the implementation of and compliance with HIPAA privacy rules and Administrative Simplification requirements, or
  - b. Customer service, including the provision of data analysis for policyholders, plan sponsors, or other customers;

- viii. Resolution of internal grievances; and Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” subject to the HIPAA privacy rules or, following completion of the sale or transfer, will become a covered entity subject to the HIPAA privacy rules.
5. **PERIOD OF COVERAGE** - For Plan benefits the Period of Coverage is generally the same as the Plan Year. However, if a person becomes a participant after a Plan Year has started, that participant’s Period of Coverage consists of his or her first day of participation and the remainder of the Plan Year. For example, if a person becomes a participant on November 1, 2005, that person’s Period of Coverage for that Plan Year is November 1 through December 31, 2005.

However, if you stop paying for these benefits, your Period of Coverage will end early. For example, if you terminate employment or take an unpaid leave of absence, your Period of Coverage will end as of the last day for which you pay for coverage (including any months paid for as continuation coverage).
6. **PLAN** - This Northwestern Health Sciences University Cafeteria Plan, as it may be amended from time to time.
7. **PLAN YEAR** - The Plan Year is the twelve-month period ending each December 31.
8. **STATUS CHANGE** - A change in your marital status or number of dependents, a termination or commencement of your spouse’s employment, a change on the part of you or your spouse from full-time to part-time employment status or vice versa, or your taking an unpaid leave of absence. The Company may add to the list of changes in circumstances that constitute Status Changes, consistent with the law relating to such Status Changes.

## **TYPE OF PLAN**

This is a flexible benefit plan that permits participants to choose among more than one benefit. It is classified as a “cafeteria plan” for federal income tax purposes.

## **BECOMING ELIGIBLE TO PARTICIPATE IN THE PLAN**

A new Eligible Employee may elect to become a participant in the Plan on the first day they are eligible to participate in the Northwestern Health Sciences University health and/or dental plan(s), and beginning after he or she becomes an Eligible Employee by satisfying the participation conditions. Thereafter, Eligible Employees may become participants on the first day of a Plan Year.

## **PARTICIPATION CONDITIONS**

As a condition to participation in the Plan and to receiving reimbursement benefits under this Plan, you must:

- (1) Eligible Employees that have elected to participate in the Company's health and/or dental plan(s) shall be deemed to have elected to participate in the premium portion of this plan, and to have the employee portion of the premium for coverage under the Company's health and/or dental plan(s) paid for on a pre-tax basis, unless written notification, on Company forms, is supplied to the Company, stating that the employee does not wish to participate in the premium portion of this plan and that the employee portion of the premium for coverage under the Company's health and/or dental plan(s) should be paid for on an after-tax basis. Eligible Employees shall have the right to waive participation in the Company's health and/or dental plan(s), and take any contributions they would have made as taxable income;
- (2) To participate in the Medical Reimbursement and/or Dependent Care portions of this Plan, each Eligible Employee shall execute and deliver to the Company, prior to becoming eligible for the Plan, a written and signed application by which the Eligible Employee applies to participate in the Medical Reimbursement and/or Dependent Care portions of this Plan. This written and signed application will also designate the required amount of Compensation for the Plan Year in question as Pay Conversion Contributions;
- (3) Authorize Pay Conversion Contributions in the required amount;
- (4) Observe all Plan rules and regulations;
- (5) Agree to inquiries by the Company with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan; and
- (6) Submit to the Company all reports, bills, and other information that the Company may reasonably require.

If you do not make a benefit election within the time period required by the Plan, you will not be eligible to participate in the Plan, until the next Plan Year.

## **PAYING FOR BENEFITS**

Benefits are paid for by you using your Pay Conversion Contribution and any available Company contributions. Both types of contributions are discussed below.

## **COMPANY CONTRIBUTIONS**

The Company may make a discretionary contribution to the Plan as it chooses. Each year, the Company will notify you of the amount, if any, of its discretionary contribution. The amount of the discretionary contribution may change from year to year, and the Company may not make a discretionary contribution in a year.

## **PAY CONVERSION CONTRIBUTIONS**

Pay Conversion Contributions are the amounts by which you reduce your regular gross (before tax) wages or salary in exchange for the Company's contribution of equal amounts to the Plan. The election to participate in the Company's health and/or dental plan(s) shall authorize the appropriate payroll deductions.

## **BENEFITS PROVIDED UNDER THE PLAN**

The types of benefits available to you under the Plan are described below. If you do not use your Company contributions, if any, or Pay Conversion Contributions to purchase benefits, such amounts will be paid to you in cash.

1. Health Plan Coverage. Payment of the employee cost of single, single plus spouse, single plus child(ren) or family coverage under the Northwestern Health Sciences University Health Plan. This health plan is described in the Health Plan Summary Plan Description.
2. Dental Coverage. Payment of the employee cost for single, single plus spouse, single plus child(ren) or family coverage under the Northwestern Health Sciences University Dental Insurance Plan. This dental insurance plan is described in the Dental Plan Summary Plan Description.
3. Medical Reimbursement. If you elect medical reimbursement coverage, you can use your available Company contributions, if any, and Pay Conversion Contributions to be reimbursed for medical expenses incurred during the Period of Coverage for a Plan Year that are related to the diagnosis, treatment, or prevention of disease or for sickness and injury. Premiums for insurance coverage and similar expenses (e.g., payments for HMO coverage) are **not** reimbursable. If you elect to receive medical reimbursement coverage, within the Plan's limits you will elect your level of coverage for the Plan Year. The maximum level of coverage is Five Thousand Dollars (\$5,000) per Plan Year.

IRS Publication 502, which you may obtain from the Internal Revenue Service, describes only tax-deductible medical expenses, which are many of the expenses eligible for reimbursement. All of the expenses described in §213(d) of the Internal Revenue Code, with the exception of long-term care, are eligible for reimbursement under this Plan. There are some key differences between Publication 502 and §213(d). Three key differences between Publication 502 and this Plan are: (1) Expenses under this Plan are reimbursable upon the date incurred and not the date paid, and goes by the Plan Year and not the tax year. (2) Health insurance premiums are NOT reimbursable through the medical reimbursement portion of this Plan. (3) Over-the-counter medicine and drugs are reimbursable under this Plan. The following list gives examples of the types of medical expenses covered. However, an expense is **ineligible for reimbursement** to the extent that it is covered by any insurance policy or will be reimbursed from any other source. In addition, expenses for cosmetic procedures that are not medically necessary are not eligible for reimbursement.

Surgical services	X-Ray treatments
Hospital services	Nursing services
Laboratory services	Dental services
Medicine and drugs	Insulin
Ambulance services	Chiropractic and osteopathic services
Pre-natal care	Chemical dependency services
Orthodontia	Psychiatric care
Vision care	Prescription eyeglasses
Contact lenses	Hearing aids
Seeing eye dogs	Wheelchairs
Tape recorders for blind persons	Crutches

As noted earlier, you can be reimbursed only for expenses incurred during your Period of Coverage for that Plan Year. In addition, no medical expense will be reimbursed under this Plan to the extent that either the expense is covered by any health or accident plan or insurance policy covering you, your spouse, or any Dependent or you will be reimbursed for the expense from another source.

4. Dependent Care Reimbursement Expenses. You may also set aside available Company contributions, if any, and Pay Conversion Contributions in a dependent care reimbursement account. This account can be used to reimburse you for amounts paid for household services or for the care of a Qualifying Individual if those amounts are paid to permit you to be gainfully employed during a period for which there is a Qualifying Individual with respect to you. If expenses are incurred outside of your household, they will be eligible for reimbursement only if they are incurred for the care of a Qualifying Individual under the age of thirteen (13) or a Qualifying Individual that spends at least eight (8) hours per day in your household. In addition, if the expense is incurred outside your home at a facility that provides care for more than six (6) individuals that do not regularly live in the facility, the facility must comply with all applicable state and local laws and regulations, including any applicable licensing requirements.

For example, if you must place your four-year old son in a child care center in order for you to work as a full-time employee of the Company, or to enable your spouse to seek employment while you remain employed by the Company, this child care expense would be eligible for reimbursement. The cost of schooling for first grade or higher is not eligible for reimbursement under the Plan, but the cost of care provided before and after school is eligible.

Subject to Plan limits, you will elect your level of dependent care expense coverage during a Plan Year. The maximum level of coverage is Five Thousand Dollars (\$5,000) per Plan Year. A pro rata portion of your annual election will be used to fund your account from time to time. At any point in time during the Plan Year you can claim reimbursement benefits in an amount equal to the remaining balance in your account.

Your account for each Plan Year only covers expenses incurred during your Period of Coverage for that Plan Year. In addition, the Plan will not reimburse you for amounts you pay for services performed by your Dependent or a Dependent of your spouse or by your child, if the child is under the age of nineteen (19). For example, a payment to your fifteen (15) year-old daughter for baby-sitting your son would not be eligible for reimbursement.

### **SPECIAL RULES RELATING TO REIMBURSEMENT BENEFITS**

1. **Forfeitures.** Federal tax laws require that your medical expense reimbursement and dependent care reimbursement benefits for each Plan Year operate on a “use it or lose it” basis. For this reason, if you do not use the entire amount available for reimbursement benefits for a Plan Year, **YOU WILL FORFEIT the unused amount,** and you will have no further claim to it.

For example, assume Jones allocates \$2,400 during 2005 to his 2005 dependent care reimbursement account. During the 2005 Period of Coverage, however, Jones and his spouse and Dependents incur only \$2,200 of expenses eligible for reimbursement under the Plan. Jones will forfeit to the Company the \$200 remaining in his 2005 account after he has been reimbursed for all of his eligible expenses.

2. The Plan Year and the Period of Coverage. You may use your reimbursement accounts for any Plan Year only to pay for reimbursement benefits for that Plan Year.

Your medical reimbursement coverage and dependent care reimbursement account for a particular Plan Year can only be used to provide reimbursement for eligible expenses incurred during your Period of Coverage for that Plan Year. For example, if you become a participant on October 1, 2005, and have elected to receive medical reimbursement coverage for your first Plan Year ending December 31, 2005, and you are employed for the full year, you can receive reimbursement only for eligible expenses incurred from October 1 through December 31, 2005, which is your Period of Coverage for that Plan Year. Expenses incurred in September 2005, or January 2006, are not eligible for reimbursement under your coverage for that Plan Year.

In the case of medical reimbursement coverage, your Period of Coverage will end as of the last day for which you made a payment. For example, if Johnson's employment terminates on September 21 and he has paid for medical reimbursement coverage through September and elects not to pay for continuation coverage with after-tax dollars (see CONTINUATION COVERAGE), his Period of Coverage would end as of the end of September. As a result, he would not be entitled to reimbursement for expenses incurred in October through December of that year. This would be true even if Johnson had elected \$1,200 of coverage during the Plan Year and, through September, had paid \$900 for the benefit. If Johnson elected to pay for continuation coverage on an after-tax basis, he would extend his Period of Coverage. (These results can differ somewhat if you take a "Family or Medical Leave, your medical reimbursement coverage terminates, and you later reinstate the coverage. See LEAVES OF ABSENCES AND FAMILY OR MEDICAL LEAVES.)

3. When is an Expense "Incurred"? A medical expense or dependent care expense is incurred when the medical or dependent care-giving rise to the expense is provided. The date of billing or payment is irrelevant.

For example, if Jones visits his dentist on December 15, 2005, is billed for the dental services on January 5, 2006, and pays the bill on January 14, 2006, Jones will have incurred the expense on December 15, 2005. Consequently, the expense would be eligible for reimbursement under Jones' medical reimbursement coverage for 2005, but not under his coverage for 2006.

4. How Do I Claim Reimbursement Benefits? If you have elected reimbursement coverage, you may claim reimbursement for eligible medical and/or dependent care expenses. You have until sixty (60) days after the close of the Plan Year to have a correct and complete claim **received by** the Claims Administrator. Benefits are paid at least semi-monthly.

To be reimbursed you must deliver a completed claim form to:

America's VEBA Solution (AVS)  
PO Box 728  
Anoka, MN 55303

You must attach a copy of your bill or receipt or other satisfactory third party documentation of the amount of the expense and the date(s) the expense was incurred (a canceled check is not sufficient). You must also certify that each expense is eligible for reimbursement under the Plan, that it has not been previously reimbursed under the Plan and that it is not reimbursable from any other source (e.g., insurance). After your claim is reviewed, processed, and approved, you will receive a reimbursement. You may check on your account information at [www.americasvebaclaims.com](http://www.americasvebaclaims.com) by clicking on "Participant Login". You may also fax your claims and documentation to AVS at (763) 767-4700. Faxed claims must be received prior to 1:00 PM Central Time on the deadline date. Claims with missing or illegible information will be denied, pending re-submission of legible information.

If an expense is eligible for both medical and dependent care reimbursements, you may choose whether to submit the expense as a medical expense or a dependent care expense. You may also submit part of the expense for reimbursement under one type of coverage, and the remainder for reimbursement under the other, but you may only be reimbursed once for any expense.

## **RESTRICTIONS ON RECEIVING BENEFITS**

Tax laws impose a variety of nondiscrimination requirements and benefits tests that must be met before benefits under the Plan will be nontaxable to all employees. These are generally intended to restrict the amount of nontaxable benefits available to certain employees of the Company who are officers, directors, or "highly compensated." If the Company believes that any of these requirements or limits may be violated, it may limit the amount of Pay Conversion Contributions certain participants may allocate to nontaxable benefits, so that the Plan and its benefits will not be discriminatory.

## **MAKING A BENEFIT ELECTION**

Prior to the start of your participation in the Plan for a Plan Year, at a time announced by the Company, you must complete and return to the Company a benefit election form setting out your benefit elections and indicating how much of your Company contributions, if any, and Pay Conversion Contributions, if any, that you want used to pay your benefits. If you do not make an initial benefit election, you will not be able to participate in the Plan, until the next Plan Year.

The Company allows negative elections for health and dental plan premiums. The Company assumes that you want to pay for these premiums with pre-tax money, but will allow the Eligible Employee to waive participation in the premium portion of the Plan, upon the completion of the appropriate waiver forms by the employee. Negative elections are not used for your medical care reimbursement and dependent care reimbursement benefits. You must affirmatively elect these benefits.

## **CHANGING YOUR BENEFIT ELECTION**

After a Plan Year begins you generally cannot change your benefit election or allocation of Pay Conversion Contributions or Company contributions, if any. However, if there is a Status Change you may change your election. Any such change must be consistent with the Status Change. For example, if a participant's spouse becomes unemployed, the participant can stop or reduce the rate of additions to his or her dependent care reimbursement account. This Status Change would not be eligible to allow a change to the medical reimbursement portion of the Plan. However, even with a consistent Status Change, you may not reduce your medical reimbursement coverage to a level lower than the amount of medical reimbursement benefits that you have already claimed for the Plan Year.

Any such change in your election must be made using Company forms prior to or after the Status Change, but not later than thirty (30) days after the date of the Status Change. Such a change will be effective as of the first payroll period for which the Company can process the change, or, if later, the actual date the Status Change occurs.

If you cease making contributions for benefits during a Plan Year because of a termination of employment (or some other reason), you will be able to make a new benefit election for that Plan Year, if you become re-employed after a period of thirty (30) days or longer. If you return to employment within thirty (30) days, the Company may re-instate your original election for that Plan Year.

**FMLA APPLIES ONLY TO EMPLOYERS WITH 50 OR MORE EMPLOYEES.**

**LEAVES OF ABSENCES AND FAMILY OR MEDICAL LEAVES**

If you take a leave of absence, that is not a Family or Medical Leave under the Family and Medical Leave Act of 1993, the way in which you may participate in the Plan will depend on whether or not you continue to receive compensation from the Company. If during a leave you continue to be paid by the Company, your benefit election will remain in effect and the Company will continue to withhold Pay Conversion Contributions. If you are not being paid by the Company, your participation in the Plan will be treated in the same way as if you had terminated employment. Thus, you cannot make contributions to your Dependent Care Reimbursement Account, but you can continue to submit claims through the end of the Plan Year or, if earlier, until your account is depleted. You can pay for your health and/or dental plan(s) premiums and any medical expense reimbursement benefits on an after-tax basis. When you return to work your prior benefit election will be reinstated.

If you take a leave of absence that is a Family or Medical Leave under the Family and Medical Leave Act of 1993, you should contact the Human Resources Department in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid Family or Medical Leave, you may continue to participate in the Plan provided you continue to pay for your benefits. You can elect to pay for your benefits in one of the following three ways:

- (1) You can pay for your benefits on a pre-tax basis by allowing us to deduct your required contributions from your paychecks before the leave. (Due to certain tax law restrictions, you can only prepay on a pre-tax basis through the end of a Plan Year.)
- (2) You can pay for your benefits for the duration of the leave on an after-tax basis by a single lump-sum payment at the beginning of the leave.
- (3) You can pay for your benefits on an after-tax basis during the leave by sending your payment to the address stated on your FMLA Specific Notice on or before the due date. There is a 30-day grace period for late payment.

If you receive taxable pay from the Company during your leave, you can pay for your benefits on a pre-tax basis through Pay Conversion Contributions from that pay. If you fail to make arrangements to pay for your benefits during a Family or Medical Leave, the Company reserves the right to recover the cost of such coverage from your compensation upon your return from the Family or Medical Leave or, if you do not return to work, to recover the cost of such coverage at the end of the Family or Medical Leave to the fullest extent authorized by the Family and Medical Leave Act of 1993.

Please contact the Human Resources Department at (952) 888-4777 as soon as you know you will be taking a Family or Medical Leave.

## **QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

In certain circumstances, you may be able to enroll a child of a participant in the Plan in the medical expense reimbursement portion of the Plan by filing a “Qualified Medical Child Support Order” (“QMCSO”) with the Company. A QMCSO may only be filed with respect to a child of a Participant in the Plan. If you are interested in more information relating to QMCSO and the procedures for filing them with the Plan, please contact the Human Resources Department.

## **HOW BENEFITS ARE TAXED**

Subject to applicable nondiscrimination requirements discussed above, the Company believes that contributions used to pay for benefits other than the dependent care benefits will not be subject to federal or state income taxes or to social security taxes. These contributions and benefit payments will not be reduced by income tax or social security withholding.

Dependent care benefits you receive from your dependent care reimbursement account during a calendar year generally will not be taxable unless they exceed the lower of (a) \$5,000 (\$2,500 if you are married but file a separate return for the year), reduced by the amount of any dependent care credit you claim for other expenses (see SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES below) or (b) your income limitation for that year. If the amount of dependent care benefits exceeds your income limitation, the excess will be taxable. If you are single, your income limitation for a year is your earned income for that year. If you are married, your income limitation is the lower of (a) your earned income for the year, or (b) your spouse’s earned income for the year. If your spouse is a full-time student or is physically or mentally incapable of caring for himself or herself during the year, your spouse will be considered to have earned income of \$250 per month if you have one Dependent who qualifies for coverage or \$500 per month if you have two or more Dependents who qualify for coverage.

However, to sustain the nontaxable status of dependent care benefits you receive from the Plan, you will be required to report the amount of those reimbursements and the name, address, and the social security number or employer identification number of the dependent care provider on your federal income tax return.

By each January 31, as part of your W-2, the Company will provide you with a statement showing the amount of dependent care reimbursement paid to you during the preceding calendar year so that you can calculate the amount, if any, that was taxable. This statement may be a part of your W-2. The Company will not withhold income taxes or social security taxes from dependent care benefit payments.

To illustrate the tax savings offered by the Plan, suppose Terry expects to be paid a gross salary of \$24,000 during the year. If Terry has 2 children and expects to have \$1,000 in medical expenses that will not be covered by insurance or any other health plan and \$1,680 of premiums for Company-sponsored health insurance (\$140 per month), Terry may pay these expenses on an after-tax basis from her salary or, by participating in the Plan, she can receive benefits from the Plan which allow her to pay the expenses with pre-tax dollars. The difference is illustrated in the following table. (For illustration purposes it is assumed that Terry contributes nothing to and receives nothing from her dependent care reimbursement account and that she pays \$1.00 for each \$1.00 of medical reimbursement coverage during the Plan Year. This also assumes that Terry will file "Single-Head of Household," and will claim three exemptions and take the standard deduction.)

	<u>Without Plan</u>	<u>With Plan</u>
Annual earnings	\$24,000	\$24,000
Medical expenses/premiums paid through Plan	-0	-2,680
Taxable compensation	\$24,000	\$21,320
Estimated Federal Income Taxes (2005 rates)	-1,504	-1,129
Social Security and Medicare (FICA) Tax (2005 rate 7.65%)	-1,836	-1,631
After-tax compensation	\$20,660	\$18,560
Medical expenses/premiums paid after-tax	-2,680	-0
Spendable income after taxes and expenses	\$17,980	\$18,560

Terry's total gross compensation, considering both gross salary and Plan benefits, will have stayed the same, but her compensation after federal taxes, medical expenses, and health insurance premiums will have increased by \$580.

The full or partial nontaxability of benefits is the primary benefit of the Plan. However, the exact effect the Plan will have on you will depend on the benefits you elect as well as other factors that affect the amount of income taxes you pay.

Note -- If you receive nontaxable reimbursement from the Plan for medical or dependent care expenses, you may not deduct or take a credit for these expenses on your tax return.

### **SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES**

Under current law, a tax credit is available for dependent care expenses of the same type eligible for reimbursement through the Plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 20% to 35% of eligible expenses up to a limit of \$3,000 of expenses if there is one eligible Dependent and \$6,000 of expenses if there are two or more eligible Dependents. As indicated above, however, you will not be eligible to take the tax credit for any expenses reimbursed through the Plan. In addition, the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent care reimbursements you receive under the Plan. For example, if you have two children and incur \$6,000 of dependent care expenses in 2005, \$2,000 of which are reimbursed through the Plan, the maximum amount of your expenses eligible for the credit would be \$4,000 (\$6,000 less \$2,000). Determining whether taking the credit or reimbursement under the Plan is more beneficial involves complex calculations. Because each individual's situation is different, the Company cannot predict whether or not it would be more beneficial to you to take the tax credit for dependent care expenses or to have your expenses reimbursed under the Plan.

### **EARNED INCOME CREDIT**

Under federal law, an earned income credit is available for individuals with lower incomes. The amount of the credit differs depending on whether or not an individual has children, and is phased out as income increases. Participation in the Plan may affect your eligibility for the earned income credit and/or the amount of the credit. You should consult your tax return instructions to determine whether this credit applies to you.

### **EFFECT ON SOCIAL SECURITY OR OTHER GOVERNMENT BENEFITS**

If you use your Pay Conversion Contributions for nontaxable benefits from the Plan, the amount of social security benefits and other government provided, pay-related benefits for which you later may be eligible may be reduced.

For example, if you earn less than the social security wage base, which is \$90,000 for 2005 (unlimited for the 1.45% Medicare portion), and you use your Pay Conversion Contributions to obtain nontaxable benefits, you will have lower earnings for social security purposes, and retirement and other benefits based on these earnings could also be reduced.

## **EFFECT ON OR OTHER PAY-RELATED BENEFITS**

Your use of Pay Conversion Contributions for nontaxable benefits from the Plan should not affect your benefits from other pay-related benefit plans. These are based on your gross pay without regard to any Pay Conversion Contributions under this Plan.

## **TERMINATION OF EMPLOYMENT**

If your employment terminates, your Pay Conversion Contributions and the Company's contributions, if any, will cease. You may be able to elect to continue certain coverages by making after-tax contributions. (See CONTINUATION COVERAGE.) If you stop making payments toward that coverage, the coverage will cease. In the case of medical reimbursement coverage, see the discussion of "The Plan Year And The Period Of Coverage" in "SPECIAL RULES RELATING TO REIMBURSEMENT BENEFITS."

## **WHAT HAPPENS IF THE PLAN IS AMENDED OR TERMINATED?**

The Company reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended your rights accrued prior to the amendment will not be affected. Your rights for periods after the amendment will depend on the amendment.

If the Plan is terminated, your Pay Conversion Contributions will cease. If the Plan is terminated, the Company expects that you would be able to continue receiving reimbursements of eligible dependent care expenses on the same basis as if your employment had terminated.

## **WHAT ARE MY RIGHTS TO CONTINUATION COVERAGE?**

Under a federal law that is commonly known as COBRA (Public Law 99-272, Title X), most employers sponsoring "group health plans" are required to offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") in certain instances where coverage under the plan would otherwise end. The medical reimbursement portion of the Plan, the Northwestern Health Sciences University Health Plan and the Northwestern Health Sciences University Dental Plan qualify as "group health coverage" for purposes of COBRA (a "COBRA plan"). This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

The Plan Administrator is the Company's Director of Human Resources at Northwestern Health Sciences University, 2501 West 84th Street, Bloomington, MN 55431-1599, (952) 888-4777. The Plan Administrator is responsible for administering COBRA continuation coverage.

If you are an employee of the Company covered by a COBRA plan you have a right to choose this continuation coverage if you lose your group health coverage under the COBRA plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by a COBRA plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the COBRA plan for any of the following reasons:

- (1) The death of your spouse;
- (2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- (3) Divorce or legal separation from your spouse;
- (4) Your spouse becomes entitled to Medicare.

In the case of an employee's dependent child who is covered by a COBRA plan (including a child born to or placed for adoption with a covered employee during the COBRA continuation period), he or she has the right to continuation coverage if group health coverage under the COBRA plan is lost for any of the following reasons:

- (1) The death of a parent;
- (2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Company;
- (3) Parents' divorce or legal separation;
- (4) A parent becomes entitled to Medicare;
- (5) The dependent ceases to be a "dependent child" under the medical reimbursement plan.

Under the law, the employee or a family member has the responsibility to inform the Company of a divorce, legal separation, or a child losing dependent status under a COBRA plan. Notice, in writing must, as described below, be given to the Company within 60 days of the happening of the event.

The required notice must contain the following information: the name, address and Social Security number of the employee; the name, address and social security number of each spouse and dependent child covered by the Health Flexible Spending Arrangement; a description of the qualifying event; and, the date of the qualifying event.

When the Company is notified, in writing, that one of these events has happened, the Company, in turn, will notify you that you (or your eligible spouse or dependent) have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Company that you want continuation coverage.

If you do not choose continuation coverage, your group health coverage will end.

If you choose continuation coverage, the Company is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the COBRA plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. The law requires that, for your Medical Reimbursement portion of the Plan, you are eligible to continue coverage through the end of the plan year only if the remaining benefits through the end of the plan year exceed the premiums that you would be required to pay through the end of the plan year.

The law provides that your continuation coverage may be cut short for any of the following reasons:

- (1) The Company no longer provides group health coverage to any of its employees;
- (2) The premium for coverage is not paid on time;
- (3) The qualified beneficiary becomes covered under another group health, unless that plan limits or excludes a preexisting condition;
- (4) The qualified beneficiary becomes entitled to Medicare benefits;
- (5) The normal time period for which continuation coverage must be allowed expires.

You do not have to show that you are insurable to choose continuation coverage. However, a person who elects continuation will be required to pay the entire cost of the continued coverage. In addition, the Company is entitled to add a 2% surcharge to each monthly premium to help defray the administrative expenses. An individual that elects COBRA continuation coverage is required to make the first contribution payment, covering the period between the date coverage would otherwise stop and the end of the month preceding the date of the payment, within 45 days after the date you file the election to continue coverage. Subsequent contributions are due on the first day of each month for which you continue coverage, and your coverage will end if you fail to pay the contribution for any month within 30 days after the due date.

This law applies to the plan(s) listed above as COBRA plans. If you have any questions about the law, please contact the Company. Also, if you have changed marital status, or you or your spouse have changed addresses; please notify the Company at the above address. You should also keep a copy, for your records, of any notices you send to the Company.

If you take a military leave of absence you may have a right to have your coverage continued under group health plans, including the medical expense reimbursement portion of this Plan. Upon your return from a military leave of absence you may have a right to reinstate your coverage without any waiting periods.

If you have questions about your COBRA continuation coverage, you should contact the Company or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). The addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **THE PLAN YEAR**

The Plan Year begins on January 1 and ends the following December 31.

## **PLAN ADMINISTRATION**

The Plan is a sponsor-administered plan, and the Plan Administrator is the Company's Director of Human Resources, whose address, business telephone number, and Employer Identification Number are:

Director of Human Resources  
Northwestern Health Sciences University  
2501 West 84th Street  
Bloomington, MN 55431-1599

Telephone: (952) 888-4777  
Employer Identification Number: 41-0684657

The Company (and persons to whom it has delegated powers, to the extent of such delegations) has total and complete authority to (1) determine conclusively for all parties all questions arising in the administration of the Plan, (2) interpret and construe the terms of the Plan, and (3) determine all questions of eligibility and status of Employees, participants, and beneficiaries under the Plan and their respective interests. Such determinations are binding on all persons, subject to the claims procedures under the Plan.

## **CLAIMS FOR BENEFITS**

If your claim for benefits is denied in whole or in part, the Company must notify you in writing of (1) the specific reasons for the denial, (2) the specific provision of the Plan on which the denial is based, (3) a description of any additional information or material necessary for you to perfect your claim (and an explanation of why such information or material is necessary), and (4) an explanation of the Plan's claims review procedure. You may have any claim that has been denied in whole or in part reviewed by the Company by filing a petition for review. If the claim is made post-service (i.e., after service is rendered), a determination must be made within 60 days after receiving your petition. This petition is required to state the specific reasons you believe you are entitled to benefits, or to greater or different benefits. The Company must give you (and your counsel) an opportunity to present your position orally or in writing. You (or your counsel) also have the right to review the pertinent documents. If you do not request a hearing, within the appropriate period after the Company receives your petition, the Company shall notify you, in writing, of its decision, stating specifically the basis of said decision and the provisions of the Plan on which the decision is based. This time period may be extended up to an additional 60 days for post-service claims if you request a hearing. The Claims Procedure is set forth in full in the Plan.

## **WHAT IF I NEED MORE INFORMATION?**

This document is just a summary of the actual terms of the Plan. You may examine a copy of the actual Plan at Northwestern Health Sciences University, 2501 West 84th Street, Bloomington, MN 55431-1599 at any time during regular working hours. You may also obtain a copy of the Plan by furnishing a written request for a copy to the Human Resources Department, at Northwestern Health Sciences University, 2501 West 84th Street, Bloomington, MN 55431-1599. There may be a charge for the expense of copying the Plan document. Since this document is only considered to be a summary, in case of any inconsistencies between this summary and the Plan, the Plan shall control.

Also, certain information concerning the Plan may be filed with the Treasury Department and the Department of Labor. Should you wish to correspond with either agency about this Plan, you must refer to Employer Identification Number 41-0684657 and Plan Number 511.

The Company's Director of Human Resources has been designated as agent for purpose of service of legal process. Also, the Plan Administrator may be served legal process. The address of the agent for service of process is the address of the Plan Administrator as shown on the preceding page.

## **WHAT ARE MY HIPAA PRIVACY RIGHTS?**

HIPAA Privacy Rules require the Plan to take sufficient steps to protect any medical information that might identify you individually from other sources and to allow you to have access to this information.

The HIPAA Privacy Rules stated in this section will become effective for the Plan when required under the applicable statutes and regulations. Therefore, the effective date could be as soon as April 14, 2003, or may be April 14, 2004 if the Plan is a small plan as defined under the regulations found in 45 CFR §164.511 et al., or the effective date may be further changed by the appropriate government agency. Additionally, definitions of capitalized terms in this paragraph are taken from the statute and regulations of the Health Insurance Portability and Accountability Act of 1996, cited above. The plan will use and disclose “protected health information” (PHI) for purposes related to health care treatment, payment for health care services, and health care operations. The plan will use or disclose PHI for any other purpose only upon receipt of an authorization from the individual. The Plan will not disclose PHI to the Plan Sponsor until the Plan has received certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions: As plan sponsor, the Company agrees:

- (1) not to use or further disclose “protected health information” (PHI) other than as permitted or required by the plan document or as required by law;
- (2) to ensure that any agents, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the plan sponsor with respect to PHI;
- (3) not to use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- (4) to be vigilant of any use or disclosure of PHI and report to the plan any use or disclosure that is inconsistent with the permitted or required uses or disclosures;
- (5) to make available PHI to you upon your request;
- (6) to provide you with the opportunity to amend PHI if inaccurate;
- (7) to provide you with an accounting of the disclosure of their PHI;
- (8) to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the Department of Health and Human Services; for compliance purposes;

- (9) to return or destroy all PHI, if feasible, if not feasible then limit further uses and disclosures to those purposes that make the return or destruction infeasible;
- (10) to ensure that adequate separation exists between employees who are authorized to use PHI and those who are not. Describe those employees or classes of employees to be given access to PHI. Restrict the access to and use by these employees. Provide an effective mechanism for resolving any issues of noncompliance by persons who have access to PHI.
- (11) that in accordance with the HIPAA Privacy rules, the following employees, or class of employees, will have access to PHI: employees with medical flexible benefit oversight responsibility.
- (12) that the individuals described in (11) above will have access to use and disclosure of PHI for plan administration functions that are performed by the Plan Sponsor for the Plan.
- (13) that the Plan Sponsor will provide a mechanism for resolving noncompliance issues for any individual described in (11) above who does not comply with the plan document, or improperly uses or discloses PHI, including disciplinary procedure.

## **WHAT ARE MY ERISA RIGHTS?**

Certain benefits offered through the Plan are provided through separate ERISA welfare benefit plans. If you elect any of these benefits, you will be a participant in an ERISA welfare benefit plan, and, as such, you will be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants of ERISA plans are entitled to:

- (1) Examine, without charge, at the plan administrator's office and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- (2) 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
- (3) Receive summaries of the plan's annual financial report. The plan administrator may be required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of ERISA employee benefit plans. The people who operate such plans, called “fiduciaries” of the plan, have a duty to administer the plan prudently and in the interests of plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the plan or exercising your rights under ERISA.

If your claim for a benefit under an ERISA plan is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials that you are entitled to receive 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 up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan’s money, or 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, in certain circumstances the court may order you to pay these costs and fees, for example, if it finds that your claim was frivolous.

If you have any questions about an ERISA plan, you should contact the plan administrator of that plan. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of Employee Benefits Security Administration (EBSA), Department of Labor.

## **SUMMARY OF ADMINISTRATIVE INFORMATION**

Name of the Plan:

The name of the Plan is the Northwestern Health Sciences University Cafeteria Benefits Plan.

Employer, Plan Sponsor and Plan Administrator:

Director of Human Resources  
Northwestern Health Sciences University  
2501 West 84th Street  
Bloomington, MN 55431-1599

Telephone: (952) 888-4777  
Employer Identification Number: 41-0684657

Claims Administrator:

America's VEBA Solution (AVS)  
PO Box 728  
Anoka, MN 55303

You may check on your account information at [www.americasvebaclaims.com](http://www.americasvebaclaims.com) by clicking on "Participant Login".

You may also fax your claims and documentation to AVS at (763) 767-4700.  
Faxed claims must be received prior to 1:00 PM Central Time on the deadline date.

Plan Numbers:

Cafeteria Benefits Plan: 511

Type of Plan:

This Plan is commonly known as a "Cafeteria Plan," and it includes a Premium Conversion Plan, a Medical Expense Reimbursement Plan, and a Dependent Care Expense Reimbursement Plan.

Type of Funding:

This Plan is funded by employee contributions made through salary reduction ("Pay Conversion") elections, and Employer contributions, if any, in the form of benefits or benefit credits under the Plan.

Type of Administration:

Records are maintained by Plan Sponsor.

Agent for Service of Legal Process:

Service may be made upon the Plan Administrator

Requests for Information:

If you have any questions regarding your benefits, please contact the Human Resources Department. All requests, appeals, elections and other communications should be in writing and should be hand delivered or sent by certified mail.

Plan Year:

January 1 through December 31.