T-FLEX
BENEFITS BOOKLET

A MULTIPLE-CHOICE BENEFITS PLAN

2010

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INTRODUCTION

There are many benefits to be enjoyed as an employee of The University of Tulsa. In addition to your salary and the many opportunities and special events associated with the university community, TU provides you an excellent selection of employee benefits. The purpose of this publication is to provide you with an overview of the benefits available.

The University of Tulsa strives to maintain a competitive and comprehensive Benefits Program. The various plans the University offers were designed to provide a broad range of coverage -- for the present to provide safeguards for family security as well as for the future to help provide retirement income.

Because your benefit plans provide financial protection, they represent an important part of your total compensation. The University of Tulsa pays the full cost of providing many of these benefits and shares the cost of the rest with you.

Your benefit programs are re-assessed annually to determine if the best coverage TU can offer is being provided. As a result, policies and plans change from time to time. Announcements from the Office of Human Resources will be sent to employees when changes occur.

This booklet provides brief descriptions of the more important plan provisions which govern your benefits. The benefits information is intended to be a summary only and is not intended to describe all plan provisions which may apply to specific situations. In all cases, the official plan documents will govern your entitlement to any benefits provided under each of the plans. **IMPORTANT**: Although this booklet contains information regarding a number of benefits, it serves as the Summary Plan Description for the Flexible Benefits Plan (called **T-FLEX**). This information may also be found on the Human Resources website at www.utulsa.edu/personnel/benefits.

THE CHOICE IS YOURS

As a regular full-time employee of The University of Tulsa, you have the opportunity to design a benefit program that best meets the needs of you and your family through the University's flexible benefits plan, called **"*T-FLEX, A Multiple-Choice Benefits Program*".** Options are available for you to select a benefits package tailored to your individual situation.

To understand how the **T-FLEX** program works, study the following information carefully. If you or your dependents are covered under another plan, please be sure you understand the coordination of benefits provisions of that plan. Although the University cannot directly advise you on the benefit plans you should select, it can provide you with information on each of the plans. In addition, in the event that you or your covered dependents should lose coverage, under a law called COBRA (the Consolidated Omnibus Budget Reconciliation Act), you and/or your covered dependents have the right to continue medical and dental coverage under certain circumstances (see page 7 for detailed information).

Please use this booklet to help you determine the right amount of coverage and calculate the various costs involved. Then, enter your choice on the ***T-FLEX Election Form*** and return it with any required enrollment forms to the Office of Human Resources **by the designated due date.**

WHO IS ELIGIBLE FOR BENEFITS?

All employees of The University of Tulsa who are regular full-time employees and who work at least four (4) consecutive months per year are eligible to participate in the benefits program. An employee's status as a full-time employee as one who regularly works at least 35 hours per week for at least four months, as a temporary or part-time employee, or as an independent contractor, will be based on TU's personnel records. TU has sole discretion to assign employees to the various categories. Even if someone works more than 35 hours per week but is assigned to a "part-time, temporary or contract" classification, that person will not be entitled to participate in this or any other welfare plan sponsored by the University.

If you meet the eligibility requirements of the previous paragraph, but the University has approved a leave of absence or you are on active duty with the U.S. Armed Forces, you may still be eligible. Please see the specific details of each benefit plan for determination of continuation of coverage while on leave of absence.

Some options provide for the participation of eligible dependents. An eligible dependent is defined as (1) your lawfully-married spouse based on Oklahoma's marriage laws (without looking at other state laws or rules) (2) your Domestic Partner based on criteria set forth by The University of Tulsa and/or (3) unmarried children under the age of 19 or up to age 25 provided they are students actively enrolled in an educational institution for at least 12 hours per semester. Verification of student status is required each Fall and Spring semester. Please submit the completed student status form to the Office of Human Resources. The form may be accessed at http://www.utulsa.edu/personnel/benefits or in the Office of Human Resources. Children include natural born children, adopted children (including those whom you are in the process of adopting), step-children who live with you more than half-time, or any child for whom you have legal custody.

Dependent children who are incapable of self-sustaining employment due to mental or physical disability and are dependent upon you for support and maintenance are eligible for extended coverage if (1) you are claiming the child as a dependent on your federal income tax return, and (2) if you furnish proof that mental or physical disability existed within 30 days after the child reaches age 19. Proof of dependent's continued disability may be required periodically.

You may elect dependent coverage when you enroll in a plan or dependents may be added later with some restrictions.. In order to add a dependent, you must have experienced a change in family status, (i.e., marriage, divorce, birth of a child, etc.), and submit the appropriate documentation to the Office of Human Resources within 31 days of your change in family status. If you do not enroll your new dependent(s) within this time period, they may not be eligible for coverage until the next annual enrollment period.

WHEN DO BENEFITS BECOME EFFECTIVE?

You may make your elections as soon as you are employed. Your benefits will become effective on the first day of the month coinciding with or following your hire date provided you have completed all the necessary enrollment information by the designated due date.

IMPORTANT: If you are a new employee, you must return your ***T-FLEX Election Form*** **within 31 days of your employment date.**

WHEN CAN YOU CHANGE YOUR ELECTIONS?

You may change your benefits during the **Annual Cross-Enrollment Period** that is held during November for the next Plan Year. The Plan Year is defined as the calendar year (January 1-December 31). If you do not submit a new ***T-FLEX Election Form***, *your previous elections will remain in effect for another full Plan Year even though the cost of your elections may change, unless there have been significant plan changes. Significant plan changes (i.e., different providers) may require a new election form to retain certain coverages for the next plan year.*

Once you have chosen your benefits, you may not change your elections for the rest of the calendar year unless you have a change in family status. If any special family status change occurs, you may elect different benefits within 31 days of the occurrence (i.e., change to single or family coverage, begin or cancel participation in the medical or dental plan, Flexible Spending accounts, etc.). The Administrator must determine that your change in benefits is consistent with the change in your status. The family status changes, as defined by the Internal Revenue Service Code Section 125, are listed below.

To change your benefits for the following reasons, you must submit supporting documentation (i.e., marriage license, divorce decree, birth certificate, etc.):

- Marital status (marriage, annulment, legal separation, or divorce)
- Domestic Partnership
- Addition or loss of dependent (i. e., birth or adoption of a child including placement for adoption, death of a spouse/domestic partner or child)
- Other changes in dependent status (i.e., child attains age 19, or age 25 if a full-time college student or is no longer eligible to be covered under your medical and/or dental plan)

To change your benefits for the following types of family status changes, you must submit correspondence from your spouse's/domestic partner's employer indicating the reason for loss of the spouse's/domestic partner's medical and/or dental coverage:

- Loss of your spouse's/domestic partner's coverage under another employee benefits plan
- Your spouse/domestic partner begins or ends employment
- You or your spouse/domestic partner change from full-time status to part-time status or vice versa
- A significant change in cost or coverage under a plan offered by the University or another employer
- Change in residence
- Beginning or end of unpaid leave

WHAT HAPPENS TO BENEFITS WHILE ON LEAVE OF ABSENCE?

If you are on an approved leave of absence, you and/or your eligible dependents may continue your benefit coverage (medical, dental, and life), subject to timely payment of required contributions, in the following circumstances:

Leave of Absence: During approved sabbaticals or other professional leaves or leaves as provided under the Family and Medical Leave Policy, you and/or your eligible dependents may continue your coverage(s) as authorized by the University.

When you are on a leave of absence with pay, your benefits remain in effect and the payroll deductions continue to be taken from the regular payroll checks. (NOTE: Vacation and Sick Leave do not continue to accrue when you are on a leave of absence.) To continue certain benefits during an unpaid leave of absence, you must pay your monthly share of the employee and dependent costs, less **T-FLEX** credits, that you would be required to pay if you were an active employee.

Military Leave: Employees who are on active duty for more than 30 days may elect to continue university sponsored medical coverage for themselves and their families for up to 18 months (similar to COBRA), but they will be required to pay the full premium for coverage. Medical coverage of less than 31 days will be provided by the employer as if the employee out on military service had remained employed.

The failure to pay any premium installment by the last working day of the calendar month, for which that premium applies, shall automatically result in the suspension of all employee and dependent coverage under this Plan until the leave of absence ends and you return to work.

RE-INSTATEMENT OF EMPLOYEE COVERAGE:

If your coverage has been suspended during your leave of absence, the coverage will be reinstated immediately upon return to full-time active employee service provided:

1. You return immediately after the cessation of the above events;
2. You complete any required insurance forms; and
3. The required contributions are resumed.

Medical claims incurred during the leave will not be paid.

CONTINUING YOUR COVERAGE

CONTINUATION RIGHTS UNDER COBRA
THE UNIVERSITY OF TULSA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This Notice is based on the Labor Department's standard notice.

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.

The Plan Administrator is the Associate Vice President of Human Resources and Risk Management. The Administrator's address and phone number are 800 South Tucker Drive, Tulsa, OK 74104-3189, (918) 631-2616. The Plan Administrator is responsible for administering COBRA continuation coverage and is the same as the "COBRA Administrator" described in this Notice.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this 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/domestic partners[*] 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/domestic partner[*] 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/domestic partner dies;

(2) Your spouse's/domestic partner's hours of employment are reduced;

(3) Your spouse's/domestic partner's employment ends for any reason other than his or her

[*]Cobra coverage for domestic partner is subject to specific provider's eligibility rules

gross misconduct;

(4) Your spouse/domestic partner becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse/domestic partner.

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 parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to (or, if applicable, the employer sponsoring the Plan), and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse/domestic partner[*], surviving spouse/domestic partner, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Notices of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Cobra Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the applicable employer if retiree coverage is offered, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the COBRA 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/domestic partner or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator. The Plan requires you to notify the COBRA Administrator within 60 days after the qualifying event occurs. You must send this notice to the Associate Vice President of Human Resources and Risk Management. All such notices must be in writing, must certify the date of the qualifying event, must identify the person to whom the qualifying event occurred, and must describe the qualifying event. For a divorce or legal separation, you must furnish a certified copy of the divorce or separation decree. The notice also must include the name and daytime and night-time phone numbers of a person who can answer questions about the notice.

Once the COBRA 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.

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[*] Cobra coverage for domestic partner is subject to specific provider's eligibility rules

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the COBRA Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination by the earlier of 60 days of (a) the date of the determination and (b) the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the COBRA Administrator. All such notices must be in writing, must certify the date of the disability, must identify the person to whom the qualifying event occurred, and must attach a copy of the Social Security Administration's determination of disability. The notice also must include the name and daytime and night-time phone numbers of a person who can answer questions about the notice.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse/domestic partner* and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse/domestic partner and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA Administrator. All such notices must be in writing, must certify the date of the second qualifying event, must identify the person to whom the second qualifying event occurred, and must describe the second qualifying event. For a divorce or legal separation, you must furnish a certified copy of the divorce or separation decree. The notice also must include the name and daytime and night-time phone numbers of a person who can answer questions about the notice.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Wayne Paulison at 800 South Tucker Drive, Tulsa, OK 74104-3189 or phone (918) 631-2616; 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 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 and COBRA 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 or the COBRA Administrator.

* Cobra coverage for domestic partner is subject to specific provider's eligibility rules

FLEXIBLE BENEFITS PROGRAM, CALLED "T-FLEX"

WHAT IS T-FLEX?

You have the opportunity to design a benefit program that best meets the needs of you and your family through the University's flexible benefits program. ***T-FLEX***, *A Multiple-Choice Benefits Program,* also referred to as a "Section 125 plan" under the IRS code, offers you multiple advantages, including:

A. SEVERAL OPTIONS

- Medical - a choice of five plan options
  HMO (Health Maintenance Organization)
  PPO (Preferred Provider Option) 4 Choices
  or cash if your eligible to waive coverage

- Dental - a choice of two plan options
  DeltaPremier
  DeltaPPO

- Flexible Spending Accounts
  Health Care
  Dependent Care

- Dependent Life Insurance

- Optional Life Insurance

- Long Term Care Insurance

B. TAX ADVANTAGES

- You can buy certain benefits with pre-tax dollars of your own.
- You have the opportunity to receive cash instead of duplicate or excess benefits.

HOW DOES T-FLEX WORK?

Although benefit needs may vary from person to person, some benefits are essential to everyone. These essential benefits include disability insurance, basic employee life insurance and retirement income and comprise the **core benefits** that the University provides every employee who is eligible for benefits.

In addition to your core benefits, the University gives you "**T-FLEX Credits**". You may use the credits as currency to buy medical or dental coverage, or you may add them to your pay as taxable income if you waive your medical and dental coverage.

The options you buy with your **T-FLEX** Credits are called "pre-tax" options. You will not be required to pay federal, Oklahoma state, or Social Security taxes on the cost of these options (i.e., medical, dental, and Flexible Spending accounts). So, if you use all of your **T-FLEX** Credits to buy pre-tax options, you will not pay federal or Oklahoma taxes on any of the **T-FLEX** Credits.

If all of your **T-FLEX** Credits are not used to buy medical or dental coverage, the remaining **T-FLEX** Credits will be converted to cash, as part of your paycheck, over the course of the calendar year. Like your salary, the **T-FLEX** Credits are subject to tax withholding and will be reported as taxable income on your W-2 Form.

Also, **T-FLEX** Credits that are converted to cash will not be considered as salary for budget planning or fringe benefits (i.e., for calculating life, retirement, or disability benefits). Some benefits (i.e. Optional and Dependent Life Insurance, Long Term Care) cannot be provided with tax-free dollars. You may pay for these optional benefits with a payroll deduction, but such deductions will be made after taxes have been deducted from your pay.

CORE BENEFITS

The following essential benefits are the foundation or "core" of The University of Tulsa Benefits Program. This is a brief outline of the benefits; see the separate summaries of each benefit for more information. (The Core Benefits are not part of **T-FLEX**.)

THE UNIVERSITY OF TULSA RETIREMENT PLAN

The University's retirement annuity plan is carried with Teachers Insurance and Annuity Association (TIAA)/College Retirement Equities Fund (CREF). When you participate in the University's retirement plan, it provides you with a retirement income benefit with several payment options, such as a lifetime annuity benefit, interest-only payments, or a lump sum payment at retirement. For more information regarding the retirement plan and TIAA-CREF, please refer to the "Summary Plan Description (SPD) for the Retirement Plan" or contact the Office of Human Resources.

The University's retirement plan is a Social Security-integrated plan. That means whenever the Social Security wage base changes, so does the University's contribution schedule to the retirement plan. Beginning January 1, 2010, the University's contribution will be 9% of annual salary up to the 2010 Social Security maximum of $106,800 and 12% of salary in excess of $106,800. There is a **two-year** waiting period for participation before the University begins contributing. Can the waiting period be waived? Yes, subject ***to the following conditions***:

- If you have previously been employed by a tax-exempt educational or research organization that was eligible to furnish their employees a tax-sheltered annuity under IRS Code Section 403(b), and

- this employment was within the last five years immediately preceding your employment with The University of Tulsa, and

- you make written request for the waiver and certify the number of years of service for the previous employment within 60 days after you become a University of Tulsa employee.

If you are granted a waiver of the waiting period, you may begin participation in the retirement plan on the first of the month coinciding with or following your employment date with The University of Tulsa.

Whether or not you are eligible for participation in the University's retirement plan, you have the option to begin participating immediately in a **Supplemental Retirement Annuity (SRA's) or a Roth 403(b)**. You can elect to invest a certain amount of your monthly income to a qualified supplemental retirement annuity or Roth 403(b) offered by TIAA-CREF.

For more information regarding the Retirement Plan, a Supplemental Retirement Annuity or the Roth 403(b), please contact the Office of Human Resources or refer to a later section in this booklet.

LONG-TERM DISABILITY

The University's long-term disability insurance plan, carried with Prudential Insurance Company, provides up to 60% of your earnings when a serious illness or injury keeps you from working. The University pays the cost of this coverage. For hourly employees, disability income benefits may begin the first of the month following three months of long-term disability and will continue during such disability. For faculty or administrative/professional employees, disability benefits may begin on the first of the month following six months of such disability. For more detailed information, please refer to the "Summary Plan Description for the Long-Term Disability Plan" at www.utulsa.edu/personnel/benefits or contact the Office of Human Resources.

GROUP TERM LIFE INSURANCE

The group term life insurance is carried with Prudential Insurance Company. The University pays the premium for your basic term life insurance coverage, which is 1.5 times your annual salary. You may buy additional employee life insurance. For more information, please see the section in this booklet called, "WHAT ARE THE AFTER-TAX OPTIONS?"

IMPORTANT: According to the IRS, you will be taxed on the value of the amount of employer-paid life insurance if the amount of your life insurance exceeds $50,000. To waive your life insurance in excess of $50,000, complete the appropriate section on your ***T-FLEX Election Form****.*

This life insurance plan offers "Living Benefit Option". In case of the employee's terminal illness (life expectancy of 12 months or less) an employee may elect to receive up to 75% to $250,000 combined Basic/Optional maximum of his or her life insurance amount. For more detailed information, please refer to the "Summary Plan Description on the Life Insurance Plan" or contact the Office of Human Resources.

Please complete the beneficiary information in appropriate section of the ***T-FLEX Election Form*** available from the Office of Human Resources. You may change your beneficiary at any time by completing a Beneficiary Change Form and returning it to the Office of Human Resources.

PRE-TAX or TAX-DEFERRED OPTIONS

Your pre-tax options are funded with **T-FLEX** Credits (given to you by the University) plus your contributions that are made before your pay is taxed.

Your pre-tax options are:

Medical coverage

Dental coverage

Flexible Spending Accounts—health care and/or dependent care

Employee contributions for medical and dental coverage and flexible spending accounts are not subject to federal, state or Social Security taxes.

MEDICAL COVERAGE

The University of Tulsa recognizes that employees and families need different levels of health care coverage. You and your family are eligible to enroll in the medical plan if you meet the benefits eligibility requirements described in the section called, "Who is Eligible to Participate?"

Selecting a medical plan may be the single most important selection you make as you design your benefits package. The features of each plan differ. Study these plans carefully before making your selection. The similarities and differences among the plans are described in the "BlueCross BlueShield of Oklahoma Summary Plan Descriptions".

The University offers a number of health care, dental and medical benefit plans. The plans that are currently available are described in the "Summary Plan Descriptions" document. Each of them has a separate SPD.

The University's medical care plan, lets you choose between health maintenance benefit options (HMO) and four preferred provider options (PPO) all administered by BlueCross BlueShield of Oklahoma(BCBSOK). A provider directory for each option may be accessed on our website at www.utulsa.edu/personnel/benefits or in the Office of Human Resources.

HMO OPTION:

When you enroll in the HMO, you and each member of your family must select a PCP (Primary Care Physician) from those listed in the provider directory. You must also use the hospital affiliated with your provider network. Each provider network has PCP's at several locations in Tulsa and the surrounding area.

Once you have selected a PCP, all of your care must be coordinated by the PCP that you have selected under the plan. For example, if you need to seek care by a specialist, you must obtain authorization or an approval to be referred to a specialist within the provider network that you have chosen. If medical services are unauthorized you may be responsible for those services. Remember the plan provides benefits only for care received directly from, or coordinated by your PCP.

PREFERRED PROVIDER OPTION:

If you enroll in one of the Preferred Provider Option (PPO) plans, you have access to a wide selection of network PPO providers. You do not have to choose a Primary Care Physician (PCP). At the time you need care, you may choose to utilize a physician within the PPO network which will result in lower out-of-pocket costs to you or you have the freedom to use a physician outside of the PPO network.

Preexisting Conditions: There is a preexisting condition clause on all of the PPO Plans. The preexisting condition exclusion period may be reduced by the amount of time of Creditable Coverage in effect prior to applying for coverage under this Plan. For additional information, please refer to the BCBSOK Certificate of Benefits or call the Office of Human Resources.

The University makes these options available and makes a contribution toward their cost. You fund the rest of the cost through monthly pre-tax payroll deductions.

Type of Coverage	PPO $2,500	PPO $1,800	PPO $1,200	PPO $500	HMO
Employee Only:					
Monthly Rate:	106.00	128.00	161.00	200.00	225.00
Minus the **T-FLEX** Credit:	<90.00>	<90.00>	<90.00>	<90.00>	<90.00>
Employee pays **pre-tax:**	**16.00**	**38.00**	**71.00**	**110.00**	**135.00**
Employee & Dependents:					
Monthly Rate:	145.00	211.00	282.00	376.00	455.00
Minus the **T-FLEX** Credit:	<90.00>	<90.00>	<90.00>	<90.00>	<90.00>
Employee pays **pre-tax:**	**55.00**	**121.00**	**192.00**	**286.00**	**365.00**

T-FLEX Credits The University makes a **T-FLEX** Credit available to each covered employee. The credit is $90 per month. You can use this credit to pay for part or all of the cost of any health insurance or dental plan offered by the University. In the alternative, you can add your **T-FLEX** Credits to your Health Care Reimbursement Account or your Dependent Care Reimbursement Account under the **T-FLEX** plan.

MUST YOU BUY A MEDICAL PLAN?

If you do not have medical coverage elsewhere, you must select one of the medical options offered because the University wants you to have medical coverage. Medical coverage helps to keep medical problems from becoming financial problems, especially in cases of serious illness or injury. If you do not qualify for

a waiver of coverage as stated below and you fail to select one of the medical plan options, you will be automatically enrolled in the PPO $500 plan.

To waive your medical coverage, you must satisfy at least one of the following conditions:

1. You certify that you are covered under another employer-sponsored plan and you must also provide evidence of that coverage (i.e. insurance card, enrollment confirmation, etc.); or

2. You certify that you have bona fide religious objections to being enrolled in a health benefits plan; or

3. You certify that you have enrolled in a health benefits plan offered by a Federally Recognized Indian Tribe.

A military medical plan is included as an employer-sponsored plan. However, any other non-group insurance does not qualify you for a waiver, nor does any association-type group plan in which you may be eligible to participate.

You must also certify that you understand that by choosing to waive your medical coverage neither you nor any of your dependents will be covered under the University's medical plans and that you must satisfy all University requirements as a condition of future enrollment.

If you qualify for waiver of coverage and you wish to do so, please complete the waiver information on the **T-FLEX** Election Form. Should you waive your medical coverage, you may use your **T-FLEX** credits to buy other benefits or convert the credits to cash. If you have not bought other benefits, this cash will be added to your regular paychecks throughout the year. Any **T-FLEX** Credits converted to cash will, of course, become part of your taxable income and are subject to tax withholding.

DENTAL COVERAGE

The Delta Dental Plan offers complete Freedom-of-Choice. At the time you need service, you have the option of selecting a participating dentist or the freedom to choose a non-participating dentist. With participating dentists, savings are possible because the network of dentists and dental specialists have contracted to provide care at negotiated fees. If you choose to use one of these participating dentists, your out-of-pocket expenses may be lower than if you select a dentist not participating in the network.

There are two options to choose from, DeltaPremier and DeltaPPO. Both options utilize the same benefit summary described below. The difference between the two options is the size of the networks of dental providers and contracted level of reimbursement. DeltaPremier network includes approximately 90% of the dentists in Oklahoma. DeltaPPO is a discounted product, offering the same plan design as DeltaPremier, however, utilizes a smaller network of providers who have agreed to lower reimbursements for treatment provided. This results in lower premium and treatment costs.

Note: If a person is not enrolled in this Plan when first eligible, benefits are limited to Class I Services during the first 12 months such person is covered by this Plan.

A list of network providers and additional information about the plan may be accessed at www.utulsa.edu/personnel/benefits or in the Office of Human Resources.

Your monthly cost	**Single**	**Family**
Delta Premier Option	$23.00	$82.00
DeltaPPO Option	$11.00	$46.00

FLEXIBLE SPENDING ACCOUNTS:

For some participants, the most valuable features of the **T-FLEX** flexible benefits program may be the two flexible spending accounts. You can use these accounts to reimburse yourself - tax free, 100% - up to the entire balance of your account for eligible expenses that you may now be paying with dollars that have already been taxed. The two types of flexible spending accounts are the **Health Care Flexible Spending Account** and the **Dependent Care Flexible Spending Account**. These accounts are not insured.

You can make contributions from your pay to fund one or both of these accounts. Your contributions will be deducted before your pay is taxed. These contributions accrue in your account(s) each payroll period. To enroll in one or both of the flexible spending accounts, please complete the appropriate section on your ***T-FLEX Election Form***.

1. HEALTH CARE FLEXIBLE SPENDING ACCOUNT

New employees or those with less than one year of service may contribute only up to $1,200 for their first year of participation. After one year of service, you may contribute up to $5,000 each year to your Health Care Flexible Spending Account.

You can use this account to pay health care and/or dental care expenses that are not payable by group plans and that the Internal Revenue Code and Regulations consider to be medical expenses. These expenses can be your or your dependents' expenses. In addition, some over-the-counter medications are eligible for payment from this account; see below:

The following is a partial list of expenses that can be reimbursed through your Health Care Flexible Spending Account:

Deductible and co-payment amounts for medical and dental benefits

All medical or dental charges in excess of "reasonable and customary" charges

Charges for "pre-existing" conditions

Eye exams, eyeglasses and contact lenses

Hearing exams, hearing aids, TDD machines, and other special equipment for the hearing impaired

Physical exams and mammograms in excess of what medical plan allows

Pap smears in excess of what medical plan allows

In-patient treatment of mental/nervous conditions in excess of what medical plan allows

Out-patient treatment of mental/nervous conditions in excess of what medical plan allows

Medical expenses of a dependent that is not covered by the medical plan (e.g., dependent parent)

Special schooling for a child with mental and/or physical handicaps

Transportation (if it is primarily for and essential to medical care and substantiated by receipts from a third party—use of private automobile not covered)

In-vitro fertilization

Extra cost of a private hospital room

Most "private duty" nursing (if medically necessary)

Extended care facility in excess of what is allowed by medical plan

Home health care in excess of what is allowed by medical plan

Hospice care in excess of what is allowed by medical plan

Chiropractic care

Guide dog expenses, extra cost of Braille books and magazines

Special equipment or modification of home or car (for details, see IRS Publication 502, available from the IRS)

Cardiac rehabilitation classes

Any other qualified expenses not fully covered by your medical/dental plan (except for pre-payments for long-term care)

A "Qualified" expense is one that you could deduct as a medical expense on your federal tax return. In addition, IRS rules allow your Health Care Flexible Spending Account to pay for over-the-counter items used to alleviate or treat specific personal injuries or illnesses. Examples of these include:

Allergy and asthma medicines, nasal sinus sprays

Antacids, anti-gas, laxatives, stomach and intestinal medicines

Pain relievers, including topical creams and oral medicines

Cough drops, throat lozenges, cough syrup, cold medicines and flu relief

Nicotine gum or patches for smoking cessation purposes

Antibiotic cream, cortisone cream, first aid spray, calamine lotion, bug bite medication

Allergy eye drops, contact lens cleaning solution

Motion sickness pills

Bandages, first aid kits, cold/hot packs for injuries

Ineligible items are those that are merely beneficial to the individual or to maintain the general health of the individual. Examples of these include:

Vitamins

Toothpaste, toothbrushes, dental floss

Shampoos and soaps

Deodorants, body sprays, perfumes

Cosmetics and eye cream

Dental bleaching or bonding

Rogaine or hair transplant

Electrolysis

Diaper service

Health club dues

Massage therapy

Marital or family counseling

A Health Care Flexible Spending Account may not be used to pay insurance, Medicare, or Health Maintenance Organization (HMO) premiums for the employee or his/her dependents. This exclusion includes premiums charged by the employee's spouse/domestic partner employer for coverage under a group health plan.

2. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (for child or elder care expenses)

Expenses means the amounts paid for expenses of a Participant for household services and for the care of a Qualifying Dependent, to the extent such expenses are incurred to enable the Participant and his/her Spouse/Domestic Partner to be gainfully employed or actively looking for work for any period for which there are one (1) or more Qualifying Dependents with respect to such Participant. If the Participant's Spouse/Domestic Partner is not working or actively looking for work, the Participant's Spouse/Domestic Partner must be a full-time student or incapable of self-care.

Notwithstanding the foregoing, if such amounts are paid for expenses incurred outside the household, they shall constitute expenses only if incurred for a Qualifying Dependent who regularly spends at least eight (8) hours per day in the Participant's household. If the expenses are incurred outside the Participant's home at a facility that provides care on a fee-for-service basis for more than six (6) individuals who do not regularly reside at that facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements. Expenses of a Participant shall not include amount paid or incurred to a Spouse/Domestic Partner or a child of such Participant who is under the age of nineteen (19) or to an individual who is a Dependent of such Participant or such Participant's Spouse/Domestic Partner.

NOTE:

In order for expenses to be reimbursable under a flexible spending arrangement the Code requires the expenses to be incurred in order for the participant and, if married, the participant's spouse/domestic partner to be gainfully employed or actively looking for work. The only exception is if the participant's spouse/domestic partner is a full-time student or incapable of self-care.

You can be reimbursed up to your annual contribution to this account, limited to $5,000 per year for eligible dependent care expenses. However, if you or your spouse/domestic partner earns less than $5,000 per year, the maximum reimbursement cannot exceed the lesser of you or your spouse's/domestic partner's income. If your spouse/domestic partner is disabled or a full-time student, the law assumes your spouse/domestic partner has a monthly income of $200 if you have one dependent or $400 if you have two or more dependents.

In addition, your expenses must be incurred by a qualified dependent. According to the IRS, qualified dependents are:

- Children under the age of 13
- A disabled spouse/domestic partner
- A relative or household member who is physically and/or mentally incapable of caring for him or herself, and whom you claim as a dependent on your tax return. A dependent adult must regularly spend at least eight hours per day in your household.

Eligible child and dependent care expenses are those that qualify for dependent care tax credits, such as:

- Nursery schools, kindergarten, and day care centers. The school or center must comply with state and local laws, serve seven or more children, and receive a fee for its services.
- Individuals, other than your dependents or children under the age of 19, who provide care in or outside your home.
- Dependent care centers that provide day care—not residential care—for dependent adults.
- Household services related to the care of a dependent.

Under the Family Welfare Reform Act, expenses eligible for the tax credit will be reduced dollar for dollar by any expenses reimbursed through a Dependent Care Flexible Spending Account. To use the tax credit or exclusion, you must show the name, address and Social Security or other tax-payer identification number of the dependent care provider on your tax returns.

ACCOUNT GUIDELINES

Both flexible spending accounts offer considerable tax advantages. The IRS has instituted certain guidelines to ensure that the accounts are used appropriately. To use the accounts to your best advantage, please keep the following considerations in mind.

- You cannot claim federal income tax deductions or credits for expenses reimbursed through the accounts.
- The accounts must be kept separate. You cannot transfer funds from one account to the other.
- Expenses must be incurred in the same period in which you established and contributed to the flexible spending account. Expenses are incurred when services are rendered, not when payment is made.
- If the funds in an account are exhausted, you must wait until the next plan year to begin contributing to and withdrawing from the account again.
- Any funds remaining in either account at the end of the plan year must (according to IRS regulations) be forfeited. At the beginning of each new plan year, there will be a limited “grace period” (until April 1 of the following plan year) during which you will be able to submit reimbursement requests for eligible expenses incurred during

the previous plan year. Although the IRS prohibits returning unused funds to individuals, these amounts will be applied toward the overall benefits program.

You may not begin, stop or alter the amount of deposits during the year unless your family or employment status changes (see the section "When Can You Change Your Elections" for more information).

GETTING REIMBURSED FROM YOUR FLEXIBLE SPENDING ACCOUNT(S)

You are reimbursed for eligible expenses after you submit a Flexible Spending Account Claim Form which can be obtained from the Office of Human Resources or on the Human Resources website, www.utulsa.edu/personnel/benefits. You must also provide a written statement from an independent third party, detailing dates and amounts of expenses, and you must certify that the claim cannot and will not be reimbursed through any other coverage whenever you submit claims. **Claims for eligible over-the-counter medications must include a receipt with the name of the drug and the date that it was purchased.** You must have at least $100 of medical expenses before submitting a claim form for the Health Care Flexible Spending Account (unless it is during the last quarter of the calendar year).

If you leave the University during the year, you have until April 1 of the following year to submit claims for qualified expenses.

You will not receive a check for the full amount of an eligible expense if:

- Your **Dependent Care Flexible Spending Account** balance is less than the expense you are claiming for reimbursement. Since your **Dependent Care Flexible Spending Account** accrues each pay period, you will be automatically reimbursed until the full claim is paid or up to your annual contribution amount.

- The amount you claim for reimbursement from your **Health Care Flexible Spending Account** exceeds the total amount you have elected to place in your flexible spending account for that year. If, for example, you submit $300 in expenses for reimbursement, but have elected to have $200 deposited into your account, only $200 could be reimbursed.

FREQUENCY OF REIMBURSEMENT

Reimbursement checks for **Dependent Care** expenses are processed twice per month, on the **10th** and the **25th.** If you wish to be reimbursed on the **10th**, completed forms and receipts must be submitted to the Office of Human Resources no later than 5 p.m. on the **1st** of the month. If you wish to be reimbursed on the **25th**, you should submit the completed forms and receipts to the Office of Human Resources no later than 5 p.m. on the **15th** of the month. An explanation of the flexible spending account will accompany each claim check.

Reimbursement for **Health Care** expenses will be once per month on the **10th**. If your claim is received by the Office of Human Resources no later than 5 p.m. on the **1st** of the month, you will receive your reimbursement check on the **10th**. An explanation of the flexible spending account will accompany each claim check.

HOW TO ESTIMATE THE AMOUNT OF CONTRIBUTION TO A FLEXIBLE SPENDING ACCOUNT

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Fill in what you think you will spend on medical and dental expenses not covered by your medical and/or dental plans. New employees or those with less than one year of service may contribute only up to $1,200 for their first year of participation. After one year of service, you may contribute up to $5,000 each year to your Health Care Flexible Spending Account.

Medical plan deductibles	___________________
Medical co-insurance amount	___________________
Dental deductible	___________________
Uncovered dental/orthodontic care	___________________
Vision care and/or hearing aids	___________________
Miscellaneous expenses	___________________
Annual Total:	___________________

This is the amount of pre-tax money you may want to contribute to your Health Care Flexible Spending Account annually.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Fill in what you think you will spend on eligible day-care, pre-school, elder care or other dependent care expenses necessary while you work. The maximum you may contribute each year is $5,000.

$________________________	X__________________________	=	$____________________
Weekly (or monthly) expenses	No. of weeks (or months) worked		Annual Total

This is the amount of pre-tax money you may want to contribute to a Dependent Care Flexible Spending Account if you decide it would be a better tax advantage.

SUPPLEMENTAL RETIREMENT ANNUITY (or tax-deferred annuity)

You have the option to have the University automatically contribute tax-deferred money from your paycheck to a Supplemental Retirement Annuity that help provide money for your retirement years. Technically, Supplemental Retirement Annuity are not a part of the **T-FLEX** Plan. You cannot apply **T-FLEX** credits to a Supplemental Retirement Annuity. You can, however, sign a salary reduction agreement to pay for a Supplemental Retirement Annuity out of pre-tax dollars. (The supplemental retirement annuity contributions would be free from Federal and Oklahoma income taxes, although you would pay Social Security and Medicare taxes).

You can buy a “tax-deferred 403(b)” annuity or mutual fund account through TIAA-CREF. To begin participation in a Supplemental Retirement Annuity, please complete the section on the **T-FLEX** Election Form, a Salary Reduction Agreement, as well as any other forms that are required by the University.

AFTER-TAX OPTIONS

Certain optional benefits cannot be included by law under a flexible benefit plan and purchased with before-tax dollars. Your contributions for these benefits are made after your pay is taxed. Your after-tax options are Roth 403(b), Optional Employee Life Insurance, Dependent Life Insurance and Long Term Care Insurance.

ROTH 403(b)

With the Roth option, your contribution is taken out of your paycheck after your income is taxed, which does not lower your current taxes. The benefits of the Roth option features deferred taxes on any earnings and tax-free withdrawals during retirement. When you withdraw funds from your Roth retirement plan, you won't pay taxes on any earnings, as long as you're at least 59½ (or disabled) and your withdrawal is made at least five (5) years after making your first Roth contribution. Withdrawals of Roth contributions are always tax-free since you have already paid taxes on the contributions. Investment options will be through TIAA-CREF. To begin participation in a Roth 403(b), please contact the Office of Human Resources at ext. 3154.

OPTIONAL EMPLOYEE LIFE INSURANCE

Optional employee life insurance is carried with Prudential Insurance Company. The University pays the premium for your basic term life insurance coverage, which is 1.5 times your annual salary. You have the option, either by payroll deduction or directly through the provider, to purchase additional life insurance.

BY PAYROLL DEDUCTION

You can elect more than the Basic Life Term Insurance and pay for this coverage through an after-tax payroll deduction. You may elect 1 to 5 times your covered annual salary to a maximum of $500,000. There is also a limit on the amount for which you may be insured without submitting Evidence of Insurability (EOI). EOI means that your enrollment will be conditioned on you furnishing information on your medical status and having your medical conditions accepted by the insurance company. Upon hire, you may get the lesser of 2 times your covered salary, not to exceed $200,000, without satisfying EOI. If you elect to enroll in or increase your coverage at a later date (i.e., annual cross enrollment), your enrollment will be conditioned on EOI.

Please note that employees are not taxed on employee-paid optional life insurance (unlike the employer-paid basic life insurance that exceeds $50,000).

If you wish to purchase more life insurance, choose one of the options listed on your ***T-FLEX Election Form***.

The rates for optional life insurance are age-rated as listed below:

Employee's Age	Monthly Rate per $1000 of Life Insurance
Under 25	$0.050
25-29	$0.060
30-34	$0.080
35-39	$0.090
40-44	$0.100
45-49	$0.180
50-54	$0.310
55-59	$0.500
60-64	$0.820
65-69	$1.380
70 +	$2.330

DEPENDENT LIFE INSURANCE

You have the option to buy life insurance for eligible dependents (spouse/domestic partner and/or dependent children). You may purchase coverage for your spouse or domestic partner in increments of $10,000 to $250,000, however, the coverage amount may not to exceed 100% of your Basic and Optional coverage amount. Upon hire, you may purchase up to $30,000 of coverage without your spouse satisfying Evidence Of Insurability (EOI). If you elect to enroll in or increase your coverage at a later date (i.e., annual cross enrollment), your enrollment will be conditioned on EOI.

You may purchase $10,000 worth of coverage for your children. There are no health requirements for this coverage. Once you have enrolled for this coverage, any additional dependent children that are added to your family become covered automatically (unlike other coverage's which require you to submit a completed enrollment form within 31 days of the family status change).

Please note that a husband and wife, who are both employed by the University, may not elect dependent life insurance on each other and/or both insure a dependent child. **A child will not be considered the qualified dependent of more than one employee.**

Employee's Age	Monthly Rate per $1000 of Life Insurance
Under 25	$0.050
25-29	$0.060
30-34	$0.080
35-39	$0.090
40-44	$0.100
45-49	$0.180
50-54	$0.310
55-59	$0.500
60-64	$0.820
65-69	$1.380
70 +	$2.330

LONG TERM CARE INSURANCE

Long Term Care Insurance fills the gap of custodial care by paying for home health care, adult day care, assisted living and nursing facility cost, should a covered person lose their ability to conduct daily activities or suffer a severe cognitive impairment. This important coverage is available to full-time employees, their spouses, domestic partners, parents, parents-in-law, grandparents, grandparents-in-law, and retirees. For more information on the Long Term Care Plan, please call ext. 3154.

WHAT HAPPENS NEXT?

Once you have read and understood the benefit options available to you and have made your elections on the ***T-FLEX Election Form***, please return the completed forms to the Office of Human Resources.

Within a few weeks, you should receive your new member packets for your medical and dental coverage, which provides basic information about how the plan works and your ID card. If you have any questions, please contact the Office of Human Resources at (918) 631-3154.

THE UNIVERSITY OF TULSA RIGHTS

As with all other university benefit plans, THE UNIVERSITY MAY AMEND, OR COMPLETELY TERMINATE, THIS PLAN AT ANYTIME FOR ANY REASON, FOR NO REASON, OR SIMPLY FOR ITS OWN FINANCIAL BENEFIT, WITHOUT OBTAINING THE CONSENT OF ANY EMPLOYEE OR COMMITTEE. The University may amend the Plan according to the terms of the Plan and its Bylaws.

ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) governs the way employers administer their benefit plans and gives plan participants certain rights and protections. Listed below are additional details related to your ERISA rights.

This Summary Plan Description is issued according to the terms of the Plan. It is not a contract. It is only a summary of benefits, and all statements in this summary are subject to the terms of the Plan documents on file in the Office of Human Resources.

This Summary Plan Description replaces any and all summaries previously issued for covered persons under the Plan. It describes the Plan in effect as of January 1, 2010.

Plan Name:	The University of Tulsa Flexible Benefits Plan a. Health Care Flexible Spending Account b. Dependent Care Flexible Spending Account
Also known as:	**T-FLEX** Plan
Employer Identification Number:	73-0579298
Plan Number:	508
Plan Sponsor:	The University of Tulsa 800 South Tucker Drive Tulsa, Oklahoma 74104-3189 918-631-2259
Type of Plan:	Section 125 Plan—Cafeteria Plan a. Health Care Flexible Spending Account b. Dependent Care Flexible Spending Account
Original Plan Effective Date:	May 1, 1988
Plan Year Ends:	December 31
Plan Administrator:	The University of Tulsa c/o Associate Vice President of Human Resources & Risk Mgt. 800 South Tucker Drive Tulsa, Oklahoma 74104-3189 Telephone: 918-631-2259
Plan Costs:	Shared by the Plan Sponsor and the Employee. The Plan Sponsor receives contributions from the Employee through **T-FLEX** salary reductions. The University pays benefits from its general assets.
Agent for Service of Legal Process:	Executive Vice President 800 South Tucker Drive Tulsa, Oklahoma 74104-3189 Telephone: 918-631-2306
Plan Benefits Provided by:	Self-funded by the Plan Sponsor

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage free of charge from your group health plan or health insurance issuer when you lose coverage under the plan or policy, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Newborns and Mothers Rights under Health Plans

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

The pre-tax money goes into a University bank account. Some technical laws say that if the bank account holds “employee money,” the bank account must be held as a trust. We do not believe that these rules apply to the bank account, but the plan document says that the bank account is a trust if the technical laws require a trust.

Claims Procedure

This procedure applies to claims under the **T-FLEX** Health Care Reimbursement Account and the **T-FLEX** Dependent Care Reimbursement Account. This procedure also applies to claims related to the University’s handling of the HMO, PPO, dental, insurance or other plans if the company providing the benefits does not have the right to decide the claim. Most of these companies have the right to decide such claims.

a. **Claims.** If you believe you are being denied any rights or benefits under a **T-FLEX** Reimbursement Account, or that the University has breached its duties in handling another Plan, you may file a claim in writing with the Officer of Human Resources. The Associate Vice President of Human Resources and Risk Management (the “Assoc. VP of HR”) or someone appointed by the Assoc. VP of HR may take evidence and arguments in the manner, and from the person, determined by that Assoc. VP of HR or his/her appointee. Within 90 days after the Office of Human Resources receives the Claim, the Assoc. VP of HR or his/her appointee will deliver a written “Decision” on the Claim, or explain the delay in rendering a Decision and then “Deliver” the Decision within a reasonable time. (A document is “Delivered” when it is hand-delivered, placed on your desk or chair, mailed to your last known address by first class mail, faxed or emailed to you with a confirmation of delivery.) If the Decision is wholly or partially adverse to you, it will specify the reasons for the Decision, the controlling Plan provisions, any information needed to review the Decision and the reasons for needing the information, and the procedure and time periods for reviewing the Decision.

b. **Appeals.** Within 60 days after the Delivery of the Decision, you or any Plan fiduciary or sponsor adversely affected by the Decision (collectively called an "Appellant") has the right to deliver a written Appeal to the Assoc. VP of HR. The Executive Vice President will appoint a "Committee" to hear the appeal on behalf of the Administrator. The Appellant will have 30 days after the Delivery of his/her Appeal to examine all pertinent Plan documents, evidence and other materials that the Assoc. VP of HR determines to be relevant to the Appeal (based on the standards described below), and to present additional written (or, in the Committee's sole discretion, oral) evidence or arguments on his/her behalf. The Committee will give appropriate consideration to all materials and arguments submitted to the Committee before the Committee considers the Appeal, even if the Committee does not receive such materials or arguments with the original appellate submission. If no Appellant appeals within 60 days after the delivery of the Decision, the Decision will become final and will bind each Appellant and the Plan. If an Appellant does file a timely Appeal, the Committee will Deliver a written appellate Opinion within 30 days after the Delivery of the additional evidence or arguments. The Opinion will be in the form described for a Decision, will describe any recourse before the courts or regulatory agencies, will offer to provide on written request and without charge the right to review and receive copies of information relevant to the Claim and Appeal, and will be final when delivered to such Appellant. No person will have the right to submit any Plan dispute to the courts or regulatory agencies until the Committee has delivered its Opinion or has failed to substantially comply with this claims and appeals procedure.

c. **Calculation of Time Periods; Extensions of Time.** The time periods stated in Subsections (a) and (b) will be based on the date on which the Claim, Appeal or other information actually is received in the Office of Human Resources. Even if a Claim or Appeal is incomplete, the time periods will begin when the incomplete Claim or Appeal is furnished in writing to such office, but the time periods for a response to the Claim or Appeal will be suspended until a complete Claim or Appeal is furnished. If the persons or Committee appointed to hear the Claim or Appeal cannot deliver a Decision or Opinion within the times specified above as extended from time to time hereunder, then, within such times, the Claimant will be notified of the date on which such persons or Committee believes that they can deliver the Decision or Opinion, and will explain why the Decision or Opinion will be delayed. The delay will not, however, extend more than 90 additional days for a Decision or 60 additional days after the Appellant Delivers his Appeal.

d. **"Relevant" Information.** Information is "Relevant" to a Claim or Appeal if:

i. It was relied upon in making the decision;
ii. It was submitted, considered or generated in the course of deciding the Claim or Appeal (even if it was not relied upon); or
iii. It demonstrates compliance with this claims procedure.

Designated Representative. A Claimant may act through a representative designated in writing and signed by the Claimant. If a Claimant designates such a representative, the person(s) hearing the Claim or the Committee may (but is not required to) rely completely on any statement or information provided by such representative, and may provide all information regarding the Participant and the claim to such representative.

e. **Dependents.** Your dependents also have the right to file a Claim and Appeal, as if "the dependent" replaced "you" throughout this claims procedure.

f. **Consistency.** The Office of Human Resources will keep a record of the Claims and their resolution, in order to determine whether subsequent resolutions of Claims are consistent with the Plan and with previous resolutions. Information on the names or health conditions of one employee is not available for review or copying by another employee, even if the information is reviewed by the Associate Vice President of Human Resources or Committee to determine the

consistency of actions. If a Claim is resolved in a manner that is inconsistent with a resolution of a similar claim, the Associate Vice President of Human Resources will note in the record the reasons for the different resolution of the Claim.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

There are two federal laws that protect the privacy of health information. These are the Family Education Rights and Privacy Act (FERPA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For students of The University of Tulsa (TU), the applicable federal privacy regulations are found in FERPA. However, it is our goal to comply with the standards of HIPAA.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Any change we make to our privacy practices will be made available to you.

FILING A COMPLAINT

We are required to place in the Notice, contact information for filing a complaint if you feel that your privacy rights have been violated. Please contact:

HIPAA Privacy Officer
Office of Human Resources & Risk Management
The University of Tulsa
800 South Tucker Drive
Tulsa, OK 74104
918-631-2306

Secretary of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201
1-877-696-6775

To file a complaint with the Secretary of Health and Human Services, you must do so within 180 days of the date on which that action that caused concern happened.

There will be no punishment or penalty for filing a complaint.
The effective date for this Notice is April 14, 2003.

Women's Health

1. **Childbirth.** HIPAA says that a Group Health Plan normally cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. In addition, a Health Plan cannot require that a provider obtain authorization from the Plan before prescribing a length of stay of the above periods.

2. **Cancer Benefits.** The Women's Health and Cancer Rights Act of 1998 requires health care plans to include coverage for mastectomies performed for reasons of illness or injury, along with procedures that are necessary for the reconstruction of the breast on which the mastectomy was performed. This coverage applies to general health-care plans and Health Care Reimbursement Accounts; it does not apply to limited plans such as dental or vision plans.

   If a beneficiary is receiving Plan benefits for a mastectomy and who elects reconstruction, the following benefits usually must be provided: Reconstruction of the breast on which the mastectomy was performed and on the other breast to produce a symmetrical appearance, prostheses (implants, special bras, etc.) and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

   Such benefits can be subject to the same deductibles, copayments and other general Plan terms.

   This section summarizes complicated laws. This section does not expand a health plan's benefits beyond what the actual laws require.

HIPAA

A law allows you some flexibility in changing health insurance coverage. This law is nick-named "HIPAA." Here are some of the HIPAA rules:

(a) **Pre-Existing Conditions.** HIPAA restricts the length of time that your next plan can limit your benefits for a pre-existing condition. If you enroll in the next plan at your earliest opportunity, the "pre-existing" restriction is a maximum of 12 months, for conditions that received treatment within the previous 6 months. If you do not enroll until later, the "pre-existing" limitation can be 18 months. A health plan cannot apply pre-existing conditions to care for pregnancy, childbirth, new dependents or children placed with you for adoption.

(b) **Tacking Coverage.** When you change to a new health plan, your 12-month or 18-month pre-existing condition limitation period will include your coverage under a previous group health plan (and some other types of health plans) if the new plan covers you within 63 days after your coverage under the former Plan ends. (COBRA Continuation coverage counts as coverage under this Plan, for purposes of tacking coverage.) If your new employer imposes a waiting period before you are eligible for coverage, the waiting period is not part of the 63-day break-in-coverage period.

For example, if your coverage under this Plan ends on May 1, you are employed by XYZ Company on June 1, and XYZ has a three-month waiting period before you can be covered by the XYZ health plan, and you are covered by the XYZ plan on September 1, you can count your coverage under this plan as part of the XYZ Company's pre-existing condition period because you only had 31 days of a break before you started your XYZ waiting period.

(c) **Certificates of Coverage.** When your coverage ends, you will receive a certificate of the period during which you were covered under this Plan. You also may request a certificate of your period of coverage under this Plan, within 2 years after your coverage under this Plan ends. To request a certificate, contact the Associate Vice President of Human Resources.

(d) **Nondiscrimination.** This Plan does not discriminate in providing coverage or eligibility under this Plan, or in charging premiums, based on your or your dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. Health plans cannot offer lower lifetime or annual maximum dollar amounts of coverage for mental health benefits unless they meet certain conditions. (This Plan

complies with the mental health requirement.)

(e) Right to Change Health Plans.

(i) **Open Enrollments.** If you or a dependent is covered by a group health plan, another group health plan for which you or the dependent is eligible must let you switch to a different group health plan during any open enrollment periods.

(ii) **Loss of coverage.** If coverage is lost at the end of a COBRA period, or as the result of a death, divorce or separation, termination of employment, reduction in hours worked or termination of employer contributions to the health plan, then the participant has a special right to enroll in another group health plan for which he/she is eligible. The beneficiary must enroll within 31 days after the coverage is lost. The beneficiary must furnish evidence to support the loss of coverage for one of the reasons stated above.

Some health plans may require you to say, in writing, that you are not joining their plan because you have coverage under another health plan. The University has this requirement. If you do not furnish this written certificate when you decline to join a University health plan, you will not have the right to enroll in a University health plan when your other health-care coverage ends.

QMCSO Rules

QMCSOs. If you are involved in a divorce or other family relations matter, the Court or a public welfare agency with special powers may require you to have your health insurer cover your non-dependent children. This Plan will recognize a "Qualified Medical Child Support Order," called a "QMCSO." You must be enrolled in this Plan (or in some other health plan sponsored by us) in order for the QMCSO to require coverage for a non-dependent child. The University's Office of Human Resources will review a court or agency order and will determine whether it is a QMCSO, within 30 days after the Office of Human Resources receives it. (In some cases, the Office of Human Resources may notify you of a delay.) If the Office of Human Resources determines that such an order is not a QMCSO, you and others affected by the determination may file a request for review or appeal and submit to the Executive Vice President. If HMO, insurance or similar coverage is requested, your QMCSO may be subject to review by the HMO, insurance or other company instead of the Office of Human Resources, in which case that company will make the QMCSO determination based on its rules and claims procedure.

A QMCSO must meet the following tests:

It must be a valid order from a divorce or domestic relations court, or of certain welfare agencies.

It must identify you by name and address.

It must identify each child who will receive the benefits under this Plan. This includes the child's name and address.

It must specifically say that the child is entitled to benefits under the specific health plan.

It must specifically say how long the child will be covered by the health plan.

It may identify a Representative of the child to receive information about the child's coverage.

If an order is a QMCSO, then the applicable health plan usually must cover the child as your dependent.

Benefits Enrollment Checklist

For New Employees or Changes Made During Cross Enrollment

1. **T-FLEX Enrollment Form:**
   Please complete this form as a record of the benefits you have elected. This also allows you to take advantage of the pre-tax savings available through ***T-FLEX***, our flexible benefits plan.

2. **Medical Enrollment Form:**
   After you have chosen a Medical Plan Option you will need to complete the online enrollment or the appropriate enrollment form. If you are enrolling in the HMO plan, please be sure to indicate the physician code of the primary care physician you choose for yourself and/or family.

3. **Dental Enrollment Form: (Optional Benefit)**
   If you wish to enroll in the dental plan, please complete the Delta Dental Enrollment Form.

4. **Waiver of Waiting Period for Retirement Plan:**
   If you qualify for immediate participation in the University's retirement plan because you have completed the service requirements at another tax-exempt educational or research organization that was able to furnish their employees a tax-sheltered annuity under IRS Code Section 403(b), please submit your request for the waiver, in writing, to The Office of Human Resources within 60 days of your employment.

5. **Evidence of Insurability:**
   If you wish to enroll or increase the amount of your optional employee life insurance and/or the amount of dependent life insurance, please complete this form on the appropriate person (either on yourself and/or your dependents) and return it to The Office of Human Resources with your enrollment forms.

   IMPORTANT:

   If you are a new employee you must return your Election Forms to the Office of Human Resources **within 31 days of your employment/eligibility date** or certain restrictions may apply.

This booklet was prepared from the information that appears in the official plan documents or policies. We suggest you keep this booklet as a reference guide. For more detailed information, please refer to the summary plan descriptions which are periodically distributed to employees or contact the Office of Human Resources.

Should an inadvertent discrepancy arise between this brochure and the language of the plan documents or University policy manual, the official documents must govern. You may review the plan documents during regular business hours at the Office of Human Resources.

The University of Tulsa reserves the right to modify or discontinue any of the benefits listed, at any time, in its sole discretion.

WHO TO CALL FOR BENEFIT INFORMATION

GENERAL QUESTIONS: claim forms, change forms, flexible spending account information, etc.	Office of Human Resources 800 South Tucker Drive Tulsa, OK 74104-3189 **Telephone:** **Internet**	 **918-631-3154** www.utulsa.edu/personnel
DENTAL PLAN: Group No. Premier #27240001 Preferred #27240011	Delta Dental P. O. Box 548809 Oklahoma City, OK 73154-1809 **Telephone** **Internet**	 **1-800-522-0188** www.deltadentalok.com
DISABILITY CLAIMS: Control No. 41796	Prudential Insurance Company of America Disability Management Services P O Box 13480 Philadelphia, PA 19176 **Telephone**	 **1-800-842-1718**
LIFE INSURANCE CLAIMS: Control No. 41796	Prudential Insurance Company of America Group Life Claim Division P O Box 8517 Philadelphia, PA 19176 **Telephone**	 **1-800-524-0542**
LONG TERM CARE: Group No. 41796	Prudential Insurance Company 751 Broad Street Newark, NJ 07102 **Telephone** **Internet**	 **1-800-732-0416** **www.prudential.com/gltcweb**
MEDICAL PLANS: PPO Group No. 992060 HMO Group No. YY0556	BlueCross BlueShield of Oklahoma 1215 S. Boulder Tulsa, OK 74102-3283 **Telephone:** **Internet**	 **1-800-672-2567 – PPO** **918-561-9933 - HMO** www.bcbsok.com
RETIREMENT PLAN: For information on accumulations, changing your investments, repurchases, retirement income, etc.	Teachers Insurance and Annuity Association (TIAA) College Retirement Equities Fund (CREF) 730 Third Avenue New York, NY 10017 **Telephone:** **Internet**	 **1-800-842-2776** www.tiaa-cref.org