

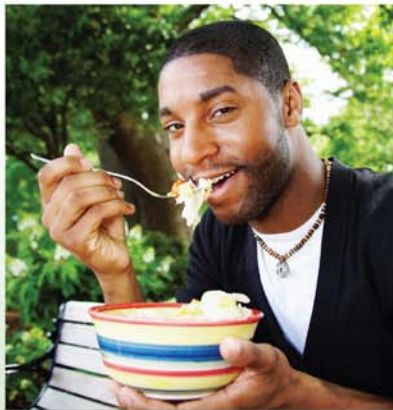


PARKER | SMITH | FEEK

2010

Open Enrollment

and Summary of Material Modifications



Whitman College

Medical

Dental

Vision

Flexible Spending Plans



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It is, once again, that time of year when the College reviews our employee benefits plans and makes decisions about future offerings.

With the sale of Great-West to CIGNA, our healthcare benefits are going to be transitioned to CIGNA's system effective January 1, 2010. The transition will result in some changes to our medical & dental benefits which we could not control. So we decided that since changes are going to take place anyway, this was a good time to review our plan as well as some other options for our program. Your Faculty and Staff Advisory Committees have worked very hard these last few months reviewing alternative medical plan options to fit our needs.

Based on that review, we decided to change our medical, dental and vision administration from Great-West to Premera Blue Cross effective January 1, 2010. The decision was both financial (Premera's pricing is more favorable) and administrative (Premera has a strong local presence, and offers national and international PPO networks). You will find that Premera is easy to work with, their name is well recognized, and they offer web tools that support your health and well being.

Following is an overview of the plan benefits and costs, and the open enrollment process. Please take a few minutes to review this important information so you can make the best health care coverage decisions for you and your family.

Medical, Prescription, Vision – Premera Blue Cross

While Premera will take over the administration of our benefits effective January 1, our plans will continue to be self-insured. Being self-insured means that the College **reimburses Premera** for the cost of your claims! So when you incur healthcare expenses, the College actually pays for your claims, not Premera. (However, we do purchase "stop loss" insurance to protect the College against catastrophic expenses.)

Our medical plan will continue to provide better benefits (i.e. you pay less) when you use preferred providers who are part of the Premera network. The additional advantage of using preferred providers is that both you and the plan receive discounted services! The Premera network is robust not only here in Walla Walla, but throughout Washington State, across the country, and around the world. You have three ways to determine whether your doctor is in the network:

1. Visit **www.Premera.com** and select the "Provider Directory" tab on the top bar. You may then search by name or specialty for: Physicians (including specialists, therapists), Facilities

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2. (including hospitals, labs, radiology, urgent care centers) or Pharmacies. You must choose a network - ours in Washington is the "Heritage" network. You then give geographic information as specific as you want – you can give as much as an entire address, or as little as a zip code - and choose a search range. To look for a provider outside Washington, go to the "other states" bar and select "Blue Card PPO".
3. Call Premera's customer service number at 800.722.1471.
4. Call your provider's office and ask if they are a preferred provider with Premera.

You are not **required** to use preferred providers. If you receive care from a provider that is not in the Premera network, you will still have coverage but your share of the cost will be a lot more.

With our move to Premera, there will be some changes to the medical plan due to Premera's system capabilities and plan offerings. We have reviewed each benefit and have worked hard to make the changes as minimal as possible. Please review the benefit summary included in this packet for details of the medical (and other) benefits effective January 1, 2010. The basic elements will be the same: Same deductible, coinsurance, out-of-pocket maximum, copayments, etc. Some of the changes you will see are shown below, and are assuming you use preferred providers:

- Charges for outpatient care by physicians, chiropractors, physical therapists, mental health providers, etc. will be covered at 100% after a \$20 copay, no deductible
- Routine colonoscopies will be covered at 100%, no deductible. This does not include colonoscopies performed as a result of a diagnosed illness.
- Over the counter smoking cessation aids such as nicorette or nicotine replacement patches will be covered under our drug plan, up to a maximum paid of \$250 per calendar year
- Chiropractic care and acupuncture treatment will have a limit of 12 visits each per person, per calendar year
- Outpatient diagnostic x-ray and lab services will be covered at 80%, no deductible
- Outpatient surgery will be covered at 80% after the deductible for both physician and facility charges

Services from non-preferred providers are covered at 60% after you have met the deductible.

Our medical benefits are designed to encourage routine physicals and well child care, and taking care of "the small stuff" when it comes up. It also protects you in case you experience a catastrophic medical event. How? Like our current medical plan, office visits and annual physicals will cost you only \$20 when you use a preferred provider; screenings and lab work will cost you

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20% of the bill; and you pay the applicable copay (\$10, \$20, or \$40) for medications, based on the type of drug you buy. In all these situations, you don't have to satisfy the deductible before you receive benefits.

If you become seriously ill or injured and have expensive healthcare bills in any one calendar year, you will pay the first \$350 of those expenses in order to meet the deductible, and then you will pay 20% co-insurance for the cost of medically necessary care. Once you have paid \$2,000 in co-insurance, the plan will pay 100% for the rest of the calendar year!

Vision benefits continue to be part of our medical plan. You may have an annual vision exam for a \$20 copay, and you are given an allowance of \$150 per calendar year to pay for lenses/frames.

For more detailed information about these benefits, please refer to the summary included in this enrollment kit. To learn more about the Premera organization, visit www.Premera.com.

Transition of Medical Care and Deductible Carryover

Many of you may have already scheduled surgeries for December or January to take advantage of the end-of-year break. Because of the change in administrators, you may have questions about which administrator (Great-West or Premera) will pay for those services, and how the transition will work.

If you have surgery scheduled for December 2009, your providers will continue to work with Great-West for prior authorization and claim payment. If you need follow-up care after December that is directly related to the surgery, those costs should be included in the cost of the surgery so there will be no need to file a claim with Premera. If you need treatment after January 1 that is NOT included in the cost of the surgery, then work with Premera.

If you have surgery scheduled for January 2010, those claims will go to Premera. They do not require prior authorization for any surgery, with the exception of obesity surgery such as gastric bypass or lap banding.

DEDUCTIBLE

Our plan with Great-West has a deductible carryover feature which means any deductible **satisfied** during October, November and December of 2009 will be used to satisfy the deductible for 2010. Great-West will provide a report to Premera in January which will show any carryover amounts. So if you're someone whose deductible is met during the last quarter of 2009, you will not have to satisfy a new deductible in 2010.

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Premera Prescription Plan – Medco Health

Premera uses Medco Health for managing the pharmacy benefits. In order to have the highest level of coverage for your prescriptions, and the lowest out-of-pocket costs, you must use the services of a Medco retail pharmacy. Some of the local pharmacies in the Medco network are:

Albertson's/Sav-on	Bi-Mart	Costco
Tallman's	Rite Aid	Safeway Pharmacy
Medicine Shoppe	Shopko Pharmacy	Wal-Mart

Plus there are many other pharmacies in the network. To find a network pharmacy, go to www.Premera.com and follow the same directions for finding any other provider (see above).

As mentioned earlier, the prescription copays will remain the same under our new plan: \$10 for generics, \$20 for preferred brands, and \$40 for all other brands. However, Premera's list of preferred brand drugs (\$20 copay) is different from Great West's. To determine whether your medications are on Premera's preferred drug list, visit www.Premera.com:

1. Select "Pharmacy" from the menu at the top of the page, then click on "Overview"
2. Under "Drug Information", and click on "View Printable Drug Lists"
3. Since you don't yet have your ID card, you must enter your drug plan type which is "3-tiered" and use the Washington drug list.

The "Washington drug list" is a brochure that describes the Premera pharmacy program, including the preferred drug list. We will have several copies on hand at the information meetings, so if you don't have access to the web, you can pick-up a list at a meeting.

If you use the Mail Order program and wish to continue using it after January 1, you must get a new prescription from your physician and send it to Medco, along with the completed home delivery forms. If you are taking medications on an on-going basis and are not currently using the Mail Order program, now is a great time to start! This program provides the convenience of having medications delivered to your door, refills by web, e-mail or phone, and you receive three months worth of supplies for the cost of only two months....which equates to receiving four months of free medications during the course of a year! There is a pharmacy packet included with these materials that has more information, including the mail order forms.

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Dental – Premera Blue Cross

Our dental benefits will also be with Premera effective January 1, 2010. The coverage will be the same as it is with Great-West, but with one enhancement: Premera has a network of preferred dentists! Your use of a preferred dentist is completely voluntary, but if you choose to use one, you will receive a discount on their services and they won't be able to bill you for any amounts over their discounted fee. To find a preferred dentist, go to **www.Premera.com** and follow the same procedure as when looking for a medical provider.

How Much Will Coverage Cost Me?

Whitman will continue to pay the full cost of medical, prescription and vision coverage for eligible employees, and 50% of the cost for eligible dependents. You will be responsible for the remainder of the dependent cost for these benefits. With the change to Premera, our medical, prescription and vision plan costs increased just 4.5% for 2010. Monthly payroll deductions will be:

Medical, Prescription & Vision	Total Cost	You Pay	Whitman Pays
Employee Only	\$606	\$0	\$606
Spouse/Domestic Partner	\$514	\$257	\$257
Child(ren)	\$464	\$232	\$232
Family	\$978	\$489	\$489

The College will continue to pay the full cost of the dental coverage for eligible employees, and you will pay the full cost of coverage for your dependents, but that cost won't change for 2010. Your monthly payroll deductions will continue to be:

Dental	Total Cost	You Pay	Whitman Pays
Employee Only	\$41	\$0	\$41
One Dependent	\$50	\$50	\$0
Two or more Dependents	\$117	\$117	\$0

Please note that your contributions for dependent coverage will be taken out of your paycheck each month on a pre-tax basis, as allowed by Section 125 of the Internal Revenue Code. IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that

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election until the next Open Enrollment period, unless you have a change in family status such as marriage, divorce, or birth of a child, as well as other scenarios. This means you may not discontinue coverage for a dependent during the year without experiencing a qualified change in family status.

Flexible Spending Plans – Universal Plan Administrators

Our Flexible Spending Plan (FSP) allows you to use pre-tax dollars to reimburse yourself for out-of-pocket health care expenses (such as copays and deductibles), and/or dependent care expenses. In effect, you ask Universal Plan Administrators to set up an account into which you deposit pre-tax dollars from every paycheck. Like your premium contributions, these FSP accounts are permitted by Section 125 of the Internal Revenue Code and, as such, there are rules associated with them.

The healthcare account is separate from the dependent care account. You can set up a healthcare account, a dependent care account, or both...but they are separate, meaning you cannot use funds from your dependent care account to pay for healthcare expenses, and vice versa. There are limits on the amounts you may deposit each year: \$4,000 for the healthcare account, and \$5,000 per household for the dependent care account*.

Be careful when making your election because any money left in your account at the end of the year will be forfeited – in other words, **use it or lose it!** And, once you elect the amount(s) you want to deposit for the year, you cannot change or discontinue those deposits unless you experience a change in family status. So be sure to elect to set aside money that you KNOW you will need – don't use these accounts as a "rainy day fund".

For you are currently participating in the healthcare account and cannot use up the balance of your account by 12/31/2009, you will be allowed an additional two months to incur expenses. You must incur expenses by 2/28/2010, and file for reimbursement by 3/31/2010.

We also offer the Individual Insurance Reimbursement Account. It works like much like the FSP's, but with some special rules. Please refer to the Flexible Spending materials in this packet for additional information.

**The \$5,000 per household maximum assumes you are single, or married filing jointly. If your tax filing status is otherwise, please consult your tax advisor.*

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This is the only time of year you may add or delete coverage for yourself or your dependents. Please be aware that any dependents added at this time will be subject to pre-existing condition limitations. Note that if you do not enroll an eligible dependent now due to the existence of coverage through another employer, you may add that person onto our plan only during next year's Open Enrollment Period, unless you experience a qualified family status change.

Because of our change to Premera, everyone who wants coverage for medical and dental after January 1, 2010 will have to complete a Premera Member Enrollment Form. These forms are in the back of the Premera folder, which is included in this packet. If you cannot remember your original hire date, we'll fill it in for you. Also, if you have dependent children who are not living with you, be sure to put their address on the enrollment form and Premera will send their ID card directly to them. Premera must also have your and your dependents' Social Security Numbers as part of the Medicare Secondary Payer requirements. If you or your covered dependents have coverage through another health plan, you must complete the "Other Coverage Questionnaire Enrollment" form.

Premera does not use your SSN as your member ID; you will be assigned a special member ID number which will be on your ID card. Expect to receive your new Premera ID cards at the end of December. Each covered family member will have their own card.

What Do I Have To Do?

- EVERYONE MUST complete a Premera enrollment form for medical and dental benefits if you intend to be covered for these benefits. Remember, there is a one year wait for dental.
- If you or your covered dependents are covered by another group health insurance plan, complete the "Other Coverage Questionnaire Enrollment" form.
- Complete the Whitman College Open Enrollment form. This is where you make your election for the 2010 Flexible Spending Plan. If you are currently enrolled and wish to participate again in 2010, you must re-enroll; enrollment does not carry over from year-to-year.
- Come to a meeting to learn more! Meetings will be held throughout the day on Thursday, November 5th.

**ALL FORMS MUST BE SUBMITTED TO HUMAN RESOURCES BY
FRIDAY, NOVEMBER 13, 2009**

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Who Can I Contact With my Questions?

- Premera customer service at 800.722.1471 or www.Premera.com. In the next few weeks, Premera will be able to answer only general questions while they load our benefits and enrollment data into their system. They will be able to answer Whitman-specific questions beginning in early December.
- Carol Harris in Human Resources – 509.527.5941 or harrisca@whitman.edu
- Our Benefits Consultants Cori DiBlasi, Jodie Kyler or Sally Borte of Parker, Smith & Feek at 425.709.3600 or eBenefits@psfinc.com

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Required Annual Notices

Special Enrollment

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), allows a special enrollment period in addition to the regular open enrollment period. Only the following individuals may enroll outside the open enrollment period:

- Individuals who previously waived coverage under this program because they had other coverage and then involuntarily lost the other coverage. Enrollment must occur within 30 days of the loss of other coverage;
- New dependents due to marriage, birth, adoption or placement for adoption. The eligible employee and other dependents who previously did not elect to be covered under the employer's health care plan may also enroll at the time the new dependent is enrolled. Enrollment must occur within 30 days of date of marriage, or 60 days of a birth, adoption or placement for adoption;
- A court has ordered coverage be provided for a spouse or minor child under this plan and request for enrollment is made within 31 days after issuance of such court order;
- If employee and/or dependent(s) become ineligible for Medicaid or the Children's Health Insurance program and request coverage under our plan within 60 days of termination; or
- If employee and/or dependent(s) become eligible for the state premium assistance program and request coverage under our plan within 60 days after eligibility is determined.

Notice regarding the Women's Health and Cancer Rights Act of 1998

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications of mastectomy, including lymphedema.

These benefits may be subject to annual deductibles and coinsurance provisions that are appropriate and consistent with other benefits under your plan or coverage.

Medicare Part D

The medical plans offered by Whitman provide prescription drug coverage that is at least as favorable as the Medicare Part D drug benefit that is now available. Our plans offer what is called "creditable coverage", which allows a Medicare eligible person to avoid buying the Part D benefit. As long as the benefit meets the definition of "creditable coverage", the Medicare eligible person will not have to buy a Part D plan, and will not be subject to the 1% per month late enrollment charge assessed by Part D. If you have questions about your options, please contact Human Resources, or our Benefits Consultants at Parker, Smith, & Feek.

COBRA

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact our HR Department for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a dependent child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact HR.

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