

A black and white photograph of two hikers ascending a steep, snow-covered mountain peak. The hiker in the foreground is slightly behind the one in front, both using trekking poles. The sky is overcast and the overall scene is desolate and high-altitude.

Benefits Enrollment Guide

Your Guide to Piper Jaffray
2004 Health and Welfare Benefits

- Health Care
- Dental Care
- Life Insurance
- Accidental Death & Dismemberment
- Disability
- Health and Dependent Care Reimbursement Accounts
- Transportation Program
- Paid Time Off

Other Benefit Resources

HR Direct

Piper Jaffray HR employees who are available by phone to answer questions about benefits and compensation.

612 303-6246 or toll free at
1 888 HR PIPER (888 477-4737)
7:30 a.m. to 5 p.m. (Central)
Monday through Friday

My HR Info

The Piper Jaffray employee self-service site on Trading Post used to update your personal information and view your pay advice, pay history and enroll in and view your benefits.

Access online via the HR site on Trading Post.

HR Guide

Printed newsletter distributed several times throughout the year to help guide you through important HR and benefits decisions.

Access online via the HR site on Trading Post, or call HR Direct for copies.

Benefits Handbook

Summary plan descriptions (SPDs) for all health and welfare benefits will be available online via the HR site on Trading Post. In addition, managers and supervisors have hard copies of the handbook as a department reference.

Table of Contents

General Information	1
Health Care	3
Dental Care	12
Life Insurance	14
Accidental Death & Dismemberment Insurance	15
Disability	15
Health and Dependent Care Reimbursement Accounts	16
Transportation Program	17
Paid Time Off	17
How to Enroll	18
Important Resources	20

This booklet provides a brief overview of your benefit options. In all cases, this booklet is not part of the official plan/program documents, nor is it used to administer the plans/programs. If there is a discrepancy between this booklet and the official plan/program documents, the official plan/program documents govern.

GENERAL INFORMATION

Piper Jaffray Benefits Program

Many companies offer employees a standard benefits package. But Piper Jaffray believes that benefits should be a matter of choice. Our benefits program supports this philosophy. The program is flexible—it allows eligible employees to make choices from a comprehensive range of benefit options that are competitive within our industry. This program allows you to:

- Select the benefit features that are most important to you;
- Elect the level of benefit protection that best suits the needs of you and your family; and
- Pay for most benefits with before-tax dollars.

The choices you make during your enrollment affect you and your family throughout the entire year, so it is important to know all you can before you make a decision. Be sure to review this enrollment guide prior to making your benefit selections.

Default Program of Benefits

During Annual Enrollment, eligible employees are required to affirmatively make elections, even if you plan to waive coverage. If you fail to affirmatively make your enrollment elections (or waive coverage) you automatically receive the Default Program of Benefits for which you are eligible. The Default Program will not be based on elections and coverage levels you had the previous year. If you are in the Default Program, you will receive only the following company-paid benefits:

- Basic Life Insurance;
- Short- and Long-term Disability; and
- Business Travel Accident Insurance.

If you are a new full-time or regular part-time employee and do not enroll for benefits during the required enrollment period, you will receive the Default Program of Benefits for which you are eligible at the enrollment deadline.

Total Benefit Compensation

Your Total Benefit Compensation is the eligible compensation that determines your individual insurance coverages and premiums, as well as your eligible short- and long-term disability pay. Eligible compensation excludes severance pay, certain discretionary and retention bonuses, reimbursements and stock-related compensation. Your Total Benefit Compensation is included on your Enrollment Worksheet and is calculated based on the following guidelines:

Non-Commissioned Employees

- Life & Long-Term Disability Insurance: Whichever is greater—annual salary as of Sept. 30 or 3-year average of eligible paid compensation over a 12-month period from Oct. 1 through Sept. 30 (if less than 3 years then based on months worked).
- Short-Term Disability Pay: Annual salary as of your leave date.

Commissioned Employees

- Life & Long-Term Disability Insurance: Three-year average of eligible paid compensation over a 12-month period from Oct. 1 through Sept. 30 (if less than 3 years then compensation will be based on months worked).
- Short-Term Disability Pay: Trailing six months adjusted net commissions.

New/Re-Hires (up to 12 months)/Non-Commissioned

- Annual salary plus any guaranteed first year incentive and sign-on bonus.

New/Re-Hires (up to 12 months)/Commissioned

- Financial Advisor: A computation based on the previous year's gross production times 36 percent, plus the first year forgivable loan amount.
- Financial Advisor Associate (Trainees): Monthly trainee compensation annualized.
- Non-Financial Advisor: First year guaranteed annual income as defined in your offer.

Eligibility

The Piper Jaffray benefits program offers coverage to benefit-eligible employees, as defined in this guide, and their eligible dependents. Not all benefit options have the same eligibility criteria.

Full-Time Employees

If you are classified by Piper Jaffray records as a full-time employee who is regularly scheduled to work 30 or more hours per week, you will be eligible for benefits as of the first of the month following your hire date.

Regular Part-Time Employees

If you are classified by Piper Jaffray records as a regular part-time employee who is regularly scheduled to work 20 but less than 30 hours per week, you will be eligible for benefits as of the first of the month following your hire date.

Family Member and Domestic Partner Eligibility

In general, eligible family members include:

- Spouse or domestic partner; and
- Your unmarried children (natural, adopted, step or foster children), up to age 25;
- Your child if mentally or physically incapable of self-support;
- Your domestic partner’s children up to age 25.

Domestic Partner Qualifications

If you are in a qualified domestic partnership, your domestic partner and your domestic partner’s children are eligible for health care, dental care, accidental death and dismemberment insurance and life benefits. (Note: Kaiser Colorado imposes certain limitations on domestic partner coverage.) The cost of domestic partner coverage will be deducted from your pay after taxes are taken. If you elect benefits coverage for your domestic partner and subsequently marry your domestic partner, please call HR Direct within 60 days of the date of your marriage.

Change in Required Documentation for Benefit Coverage

In order to obtain benefit coverage for your domestic partner or a dependent of your domestic partner beginning in 2004, you will need a Domestic Partner Affidavit on file with Piper Jaffray. Call HR Direct to obtain an Affidavit. If you currently have a 2003 Domestic Partner Affidavit on file and will not add new dependents for 2004, you will not need to complete a new form.

When Coverage Begins

Annual Enrollment

Coverage elected during each Annual Enrollment period becomes effective the following Jan. 1.

Full-Time and Part-Time New, Newly Eligible, and Re-Hired (Re-Hired After 31 Days or More After Termination) Employees

Your enrollment period begins on your first day of employment and continues through 60 days. Once you complete your enrollment, coverage you select under the programs becomes effective the first day of the month following your employment. Enrollment materials will be mailed to your home address. If you do not make elections or waive coverage during your enrollment period you automatically receive the Default Program of Benefits. Employees re-hired within 30 days will be reinstated in the benefits elected prior to termination.

Purchasing With Before-Tax Dollars

When you elect Piper Jaffray benefits, except for Dependent Term Life Insurance, Long-Term Disability and domestic partner coverage, the cost of your coverage is deducted from your pay before taxes are taken. This reduces your taxable income and therefore reduces the taxes you pay.

When You Can Change Benefit Elections

The decisions you make during your enrollment remain in effect for the entire plan year. However, you may be eligible to change some of your benefit choices during the year if you qualify for and complete a Family Status Change form no more than 60 days after the qualifying event. Following is a list of events that may qualify for a Family Status Change during the plan year:

- A change in your legal marital status;
- Termination or commencement of a domestic partnership;
- A change in the number of your dependents;
- A change in the employment status of you, your spouse/domestic partner or your dependent(s);
- Your dependent satisfies or ceases to satisfy the eligibility requirements;
- You experience an increase or decrease in your eligible dependent care expenses or a significant change in your dependent care coverage;
- Your spouse/domestic partner or dependent is entitled to make a change in his or her elections under his or her employer’s plan;
- For the Health Care and Dental Care programs only, you, your spouse or eligible dependent loses coverage under a group health plan sponsored by a governmental or educational institution.

Review the Family Status Change section of the Benefits Handbook for a complete list of qualifying event.

When Coverage Ends

Your coverage under the Piper Jaffray plans and programs will end when one of the following events first occurs:

- You terminate employment with Piper Jaffray;
- You commence severance;
- You retire;
- You die;
- You no longer satisfy the eligibility requirements for participation;
- You fail to pay any required premiums in full by the required date;
- You request that coverage be terminated as a result of and consistent with Annual Enrollment or a Family Status Change;
- You enter military service for duty lasting more than 31 days;
- You are on unpaid leave of absence that is longer than 90 days (although certain exceptions may be made based on applicable state laws); or
- The plan or program is discontinued or amended so that you lose eligibility.

In addition to the previously listed events, coverage for your dependents will end due to:

- Divorce, legal separation or termination of domestic partnership;
- The dependent child attaining the maximum age for eligibility (generally, age 25);
- The dependent no longer satisfying the dependent criteria for participation in a plan or program; or
- A decision by you to terminate coverage as a result of and consistent with Annual Enrollment or a Family Status Change.

The following chart describes the coverage that will end, and when, if one of the events listed earlier occurs.

ON THE LAST DAY OF THE MONTH IN WHICH EVENT OCCURS:	ON THE DAY OF TERMINATION:	ON RECEIPT OF FINAL REGULAR PAY CHECK:
<ul style="list-style-type: none"> ■ Health Care ■ Dental Care ■ Employee Term Life Insurance ■ Dependent Term Life Insurance ■ Accidental Death and Dismemberment 	<ul style="list-style-type: none"> ■ Short-Term Disability ■ Long-Term Disability ■ Business Travel Accidental Insurance ■ Health Education Program 	<ul style="list-style-type: none"> ■ Health Care Reimbursement Account ■ Dependent Care Reimbursement Account ■ Transit Reimbursement Account ■ Parking Reimbursement Account

HEALTH CARE

General Information

Piper Jaffray offers a wide range of health care options, which include:

- Standard Managed Care
- Consumer Managed Care
- Consumer Managed Care Comprehensive
- Low
- Patient Choice
- Kaiser

The availability of the options depends on where you live and the availability of a provider network. Your options are listed on your Enrollment Worksheet. The health care option you choose may require that you select a primary care provider (PCP) for yourself and for each of your dependents. If you need to choose a PCP, information will be included with your Confirmation Statement. For some plans, your enrollment is not complete—and claims may not be paid—until your PCP designation is complete. For each health care option, you may waive coverage or choose from four coverage levels:

- Employee Only (yourself only);
- Employee Plus Spouse/Domestic Partner;
- Employee Plus Child(ren)/Domestic Partner Child(ren); or
- Employee Plus Family (you, your spouse/domestic partner and your dependent/domestic partner child[ren]).

Except in the case of domestic partner benefits, premiums are deducted on a before-tax basis each pay period. Coverage for all options is subject to eligibility.

How Each Option Works

Standard Managed Care (SMC)

This option will be administered by Blue Cross and Blue Shield of Minnesota. This option will have no deductible for routine doctor visits; instead the employee will pay a \$20 co-payment for each visit and there will be no pharmacy deductible. The co-insurance structure for applicable services under this option (after applicable deductibles have been met) will be 85 percent paid by plan and 15 percent paid by employee. This option will allow employees to have lower out-of-pocket costs but higher monthly premiums.

Consumer Managed Care (CMC)

This option will be available in most areas that have Blue Cross and Blue Shield of Minnesota (BCBS-MN). You may see any eligible provider for medically necessary and eligible services. If you receive services from a BCBS-MN network provider, your expenses generally will be covered at the levels described below. If you choose a non-network provider, higher deductibles and co-insurance rates will apply. This option will provide a lower monthly premium, but will have higher out-of-pocket costs, compared to the Standard Managed Care option.

Consumer Managed Care Comprehensive (CMC Comp)

This option will be available only in areas that do not have a Blue Cross and Blue Shield (BCBS) network adequate enough to be able to offer the Standard Managed Care and Consumer Managed Care options (although there may be BCBS participating providers in the area).

You may see any eligible provider for medically necessary and eligible services; however, if you receive services from a BCBS participating provider, your expenses generally will be covered at a higher level than if you choose a BCBS non-participating provider.

After you meet an annual deductible, you will pay a portion of the costs based on the allowed amounts. Any costs over the allowed amounts will be your responsibility unless you use a participating provider and will not apply to the out-of-pocket maximum. Once you reach the annual out-of-pocket limit for covered services, the plan will pay 100 percent of the allowed amount for the rest of the year for additional covered services, up to a lifetime maximum of \$1 million.

Primary Care Providers—CMC & SMC Options

- In a Point of Service (POS) location, you will need to select a primary care provider (PCP) who will coordinate your care, provide referrals to specialists when appropriate, and submit claims and other required paperwork for you. In a Preferred Provider Organization (PPO) location, you will not be required to select a PCP but you still will need to receive eligible services from physicians or specialists in the network to receive the highest level of benefits. The option name(s) listed on your Enrollment Worksheet will indicate whether it is POS or PPO.
- You may need to follow the PCP referral procedures to get the highest level of benefits for care received from specialists.
- If either your physician or your clinic leaves the network, you must select another physician or clinic affiliated with your network—you won't be able to change health care options under this circumstance.
- Eligible PCPs are listed in the Provider Directory for your area and can be found online. See the "Important Resources" section of this guide.

Low

The Low option will be available in all locations and is administered by Blue Cross and Blue Shield of Minnesota (BCBS-MN). This option will have a lower monthly premium than either the Consumer Managed Care or Standard Managed Care options, but will have a higher deductible. Employees also will be responsible for higher out-of-pocket costs.

You may see any eligible provider for medically necessary and eligible services. If you receive services from a BCBS-MN participating provider, your expenses generally will be covered at a higher level than if you choose a BCBS-MN non-participating provider. Any costs over allowed amounts will be your responsibility, except when you use a participating provider, and will not apply to the out-of-pocket maximum.

This option is designed for those employees who want to take responsibility for a larger share of their routine medical costs in return for lower monthly premiums.

Patient Choice

Generally, Patient Choice, offered through Wausau Benefits, will be available in limited areas. Under Patient Choice, expenses will be covered at a higher level when you receive services or referrals from your primary care provider. For additional information, call Patient Choice at the number listed in the "Important Resources" section. You may call HR Direct to request a Patient Choice Provider Directory.

Kaiser

Kaiser options will be available in the Denver, Colo., Los Angeles, Calif., and San Francisco, Calif., metro areas.

If you elect a Kaiser option, you will generally receive benefits only for covered services you receive from a provider within Kaiser. Kaiser's definition of dependent(s) may be different than the definition used by other options described in this document. Refer to the Kaiser materials, or contact Kaiser for details.

You can obtain additional information by calling HR Direct or the appropriate Kaiser option.

Health Care Option Comparisons

See the following pages for comparisons of the health care options available to you. Additional limitations and rules apply to many of the covered services. These comparisons are a summary of the most basic information about the benefits and their co-payments. Please see the Health Care chapter of the 2004 Benefits Handbook or contact the administrator to learn more about what is covered under each benefit (including exclusions and limitations) and additional benefits that are not included in this summary.

If there is any discrepancy between this document and the official plan/program documents, the official plan/program documents govern. The Health Care chapter of the Benefits Handbook contains a description of plan benefits, limitations and exclusions.

	Standard Managed Care In-Network	Standard Managed Care Out-of-Network	Consumer Managed Care In-Network	Consumer Managed Care Out-of-Network	Consumer Managed Care Comprehensive Participating Provider	Consumer Managed Care Comprehensive Non-Participating Provider
ANNUAL DEDUCTIBLES						
Non-Pharmacy Pharmacy Facility	N/A N/A \$250/person; \$750/family*	Combined Non-Pharmacy/Facility: \$500/person; \$1,500/family* Pharmacy: N/A	\$200/person; \$400/family* Mail: N/A; Retail: \$50/person, \$150/family* \$300/person; \$600/family*	\$600/person; \$1,800/family* Mail: N/A; Retail: \$50/person, \$150/family* \$300/person; \$600/family*	\$200/person; \$400/family* Mail: N/A; Retail: \$50/person, \$150/family* \$300/person; \$600/family*	\$200/person; \$400/family* Mail: N/A; Retail: \$50/person, \$150/family* \$300/person; \$600/family*
ANNUAL OUT-OF-POCKET MAXIMUM	Non-Pharmacy: \$1,500/person, \$4,500/family* Pharmacy: No maximum	Non-Pharmacy: \$3,200/person, \$9,600/family* Pharmacy: No maximum	Non-Pharmacy: \$3,500/person, \$7,000/family;* Pharmacy: No maximum	Non-Pharmacy: \$4,500/person, \$9,000/family;* Pharmacy: No maximum	Non-Pharmacy: \$3,500/person, \$7,000/family;* Pharmacy: No maximum	Non-Pharmacy: \$4,500/person, \$9,000/family;* Pharmacy: No maximum
MAXIMUM LIFETIME BENEFIT	No maximum*	\$1 million/person*	No maximum*	\$1 million/person*	\$1 million/person*	\$1 million/person*
OFFICE VISITS						
General Prenatal	100% after \$20 co-pay 100% after \$20 co-pay for first visit	60% 60%	80% 80% first visit, 100% subsequent visits	60% 60%	80% 80% first visit, 100% subsequent visits	60% 60%
PREVENTIVE CARE (Routine Physical, Gynecological, Hearing and Vision Exams, Well-Child Care, Immunizations and Injections, Cancer Screening, Lab and X-Ray)	100% after \$20 co-pay per visit	No coverage	100%, no deductible	No coverage	100%, no deductible	No coverage
LAB AND X-RAY	100% for routine procedures, 85% for other procedures	No coverage for routine procedures, 60% for other procedures	100%, no deductible for routine procedures; 80% for other procedures	No coverage for routine procedures; 60% for other procedures	100%, no deductible for routine procedures; 80% for other procedures	No coverage for routine procedures; 60% for other procedures
HOSPITAL SERVICES						
Inpatient Outpatient	80% for semi-private room, facility deductible applies; 80%, facility deductible applies	60% for semi-private room 60%, facility deductible applies	80% for semi-private room, facility deductible applies; 80%, facility deductible applies	60% for semi-private room, facility deductible applies; 60%, facility deductible applies	80% for semi-private room, facility deductible applies; 80%, facility deductible applies	60% for semi-private room, facility deductible applies; 60%, facility deductible applies
SURGERY						
Inpatient Outpatient	85%, facility deductible applies 85%, facility deductible applies	60% 60%	80%, facility deductible applies 80%, facility deductible applies	60%, facility deductible applies 60%, facility deductible applies	80%, facility deductible applies 80%, facility deductible applies	60%, facility deductible applies 60%, facility deductible applies
INFERTILITY	85%, facility deductible applies; 100% after \$20 co-pay for office visits; \$10,000 maximum lifetime benefit/family*	60% \$10,000 maximum lifetime benefit/family*	80%; \$10,000 maximum lifetime benefit/family*	60%; \$10,000 maximum lifetime benefit/family*	80%; \$10,000 maximum lifetime benefit/family*	60%; \$10,000 maximum lifetime benefit/family*
EMERGENCY ROOM CARE	85% after \$75 co-pay if medically necessary (co-pay waived if admitted in 24 hours); otherwise 60% after \$75 co-pay	85% after \$75 co-pay if medically necessary (co-pay waived if admitted in 24 hours); otherwise 60% after \$75 co-pay	85% after \$100 co-pay if medically necessary (co-pay waived if admitted in 24 hours); otherwise 60% after \$100 co-pay	80% after \$100 co-pay if medically necessary (co-pay waived if admitted in 24 hours); otherwise 60% after \$100 co-pay	80% after \$100 co-pay if medically necessary (co-pay waived if admitted in 24 hours); otherwise 60% after \$100 co-pay	80% after \$100 co-pay if medically necessary (co-pay waived if admitted in 24 hours); otherwise 60% after \$100 co-pay
AMBULANCE	85%	85%	80%	80%	80%	80%
PRESCRIPTIONS	Mail (required for maintenance drugs): 100% after \$25 co-pay for generic or \$45 co-pay for formulary brand or \$70 co-pay for non-formulary brand, usually up to a 90-day supply Network Pharmacy: 80% for generic (you pay \$10 min, \$50 max) or 75% for formulary brand (you pay \$10 min, \$75 max) or 70% for non-formulary brand (you pay \$25 min, \$100 max), usually up to a 31-day supply	Mail: N/A Non-Network Retail Pharmacy: 50% (you pay \$25 min, no max), usually up to a 31-day supply.	Mail (required for maintenance drugs): 100% after \$25 co-pay for generic or \$50 co-pay for formulary brand or \$80 co-pay for non-formulary brand, usually up to a 90-day supply Participating Retail Pharmacy: 80% for generic (you pay \$10 min, \$50 max) or 75% for formulary brand (you pay \$10 min, \$75 max) or 70% for non-formulary brand (you pay \$25 min, \$100 max), usually up to a 31-day supply	Mail: N/A; Non-Participating Retail Pharmacy: 50% (you pay \$30 min, no max), usually up to a 31-day supply	Mail (required for maintenance drugs): 100% after \$25 co-pay for generic or \$50 co-pay for formulary brand or \$80 co-pay for non-formulary brand, usually up to a 90-day supply Participating Retail Pharmacy: 80% for generic (you pay \$10 min, \$50 max) or 70% for formulary brand (you pay \$15 min, \$75 max) or 65% for non-formulary brand (you pay \$30 min, \$100 max), usually up to a 31-day supply	Mail: N/A Non-Participating Retail Pharmacy: 50% (you pay \$30 min, no max), usually up to a 31-day supply
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY	85%	60%	80%	60%	80%	60%
CHIROPRACTIC	100% after \$20 co-pay; \$675 annual maximum*	60%; \$675 annual maximum*	80%; \$675 annual maximum benefit*	60%; \$675 annual maximum benefit	80%; \$675 annual maximum benefit*	60%; \$675 annual maximum benefit*

*All deductibles and maximums combined (In & Out-of-Network)
Percentages in the chart reflect the amount the plan pays after the deductible is met, unless indicated otherwise. All pre-existing conditions are covered without restriction.

	Low Participating Provider	Low Non-Participating Provider	Patient Choice In-Network	Patient Choice Out-of-Network
ANNUAL DEDUCTIBLES				
Non-Pharmacy Pharmacy Facility	Combined Non-Pharmacy and Pharmacy: \$850/person, \$2,550/family* N/A	Combined Non-Pharmacy and Pharmacy: \$850/person, \$2,550/family* N/A	N/A N/A N/A	N/A N/A N/A
ANNUAL OUT-OF-POCKET MAXIMUM	Combined Non-Pharmacy and Pharmacy: \$3,500/person, \$7,500/family*	Combined Non-Pharmacy and Pharmacy: \$4,500/person, \$9,600/family*	Non-Pharmacy: \$1,500/person, \$3,000/family*; Pharmacy: No maximum	Non-Pharmacy: \$4,500/person, \$9,000/family*; Pharmacy: No maximum
MAXIMUM LIFETIME BENEFIT	\$1 million/person*	\$1 million/person*	\$1 million*	\$1 million*
OFFICE VISITS				
General Prenatal	80% 80%	60% 60%	85% after \$20 co-pay 85% after \$20 co-pay for first visit; 85% after \$20 co-pay per ultrasound and amniocentesis	70% after \$50 co-pay 70% after \$50 co-pay for first visit; 70% after \$50 co-pay per ultrasound and amniocentesis
PREVENTIVE CARE (Routine Physical, Gynecological, Hearing and Vision Exams, Well-Child Care, Immunizations and Injections, Cancer Screening, Lab and X-Ray)	No coverage	No coverage	100% after \$20 co-pay	No coverage
LAB AND X-RAY	No coverage for routine procedures, 80% for other procedures	No coverage for routine procedures, 60% for other procedures	85% after co-pay	70% after co-pay
HOSPITAL SERVICES				
Inpatient Outpatient	80% for semi-private room 80%	60% for semi-private room 60%	85% after \$250 co-pay 85% after \$50 co-pay	70% after \$500 co-pay 70% after \$50 co-pay
SURGERY				
Inpatient Outpatient	80% 80%	60% 60%	85% after \$250 co-pay 85% after \$50 co-pay	70% after \$500 co-pay 70% after \$150 co-pay
INFERTILITY	80%; \$10,000 maximum lifetime benefit/family*	60%; \$10,000 maximum lifetime benefit/family*	85% after \$20 office visit co-pay, \$50 outpatient co-pay or \$250 inpatient co-pay; 50% for injectable drugs; \$10,000 lifetime maximum benefit	No coverage
EMERGENCY ROOM CARE	80% if medically necessary, 60% if not	80% if medically necessary, 60% if not	85% after \$75 co-pay	85% after \$75 co-pay
AMBULANCE	80%	80%	85% for medical emergency	85% for medical emergency
PRESCRIPTIONS	80%	60%	Mail/Internet: 100% after \$20 co-pay for generic or \$40 co-pay for formulary brand or \$70 for non-formulary brand, up to a 90-day supply; Retail Pharmacy: 75% for generic (you pay \$10 min, \$50 max) or 75% for formulary brand (you pay \$15 min, \$70 max) or 70% for non-formulary brand (you pay \$30 min, \$100 max), up to a 30-day supply	Mail/Internet: N/A; Retail Pharmacy: 50%, up to a 30-day
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY	80%	60%	85% after \$20 co-pay; combined maximum of 50 visits for physical and occupational therapy and 25 visits for speech therapy*	70% after \$50 co-pay; combined maximum of 50 visits for physical and occupational therapy and 25 visits for speech therapy*
CHIROPRACTIC	80%; \$675 annual maximum benefit*	60%; \$675 annual maximum benefit*	85% after \$20 co-pay; up to 15 visits/year	No coverage

*All deductibles and maximums combined (In & Out-of-Network)
Percentages in the chart reflect the amount the plan pays after the deductible is met, unless indicated otherwise. All pre-existing conditions are covered without restriction.

	Kaiser Northern California	Kaiser Southern California	Kaiser Colorado
ANNUAL DEDUCTIBLES			
Non-Pharmacy	N/A	N/A	N/A
Pharmacy	N/A	N/A	N/A
Facility	N/A	N/A	N/A
ANNUAL OUT-OF-POCKET MAXIMUM	\$1,500/person; \$3,000/family	\$1,500/person; \$3,000/family	\$2,000/person; \$4,500/family
MAXIMUM LIFETIME BENEFIT	No maximum	No maximum	No maximum
OFFICE VISITS			
General	100% after \$30 co-pay	100% after \$30 co-pay	100% after \$20 co-pay
Prenatal	100% covered	100% covered	100% after \$20 co-pay
Specialist	100% after \$30 co-pay	100% after \$30 co-pay	100% after \$40 co-pay
PREVENTIVE CARE (Routine Physical, Gynecological, Hearing and Vision Exams, Well-Child Care, Immunizations and Injections, Cancer Screening, Lab and X-Ray)	100% after \$30 co-pay (Well Baby visits covered with no co-pay up to 24 months)	100% after \$30 co-pay (Well Baby visits covered with no co-pay up to 24 months)	100% after \$20 co-pay
LAB AND X-RAY	100%	100%	100% for diagnostic; 100% after \$40 co-pay for therapeutic X-rays
HOSPITAL SERVICES			
Inpatient	100% after \$500 co-pay for semi-private room in plan hospital	100% after \$500 co-pay for semi-private room in plan hospital	100% after \$300 co-pay for semi-private room in plan hospital
Outpatient	100% after \$30 co-pay	100% after \$30 co-pay	100% after \$50 co-pay
SURGERY			
Inpatient	100%	100%	100%
Outpatient	100% after \$30 co-pay per procedure	100% after \$30 co-pay per procedure	100% after \$50 co-pay per procedure
INFERTILITY	50% for infertility services	50% for infertility services	50% for infertility services; drugs not covered
EMERGENCY ROOM CARE	100% after \$100 (co-pay waived if admitted \$500 inpatient co-pay would apply)	100% after \$100 (co-pay waived if admitted directly to the hospital, \$500 inpatient co-pay would apply)	100% after \$100 (co-pay waived if admitted directly to the hospital, \$300 inpatient co-pay would apply)
AMBULANCE	100% after \$50 co-pay per trip	100% after \$50 co-pay per trip	100% after \$50 co-pay per trip
PRESCRIPTIONS	Mail: Refills only; Retail Pharmacy: 100% after \$10 co-pay for generic or \$30 co-pay for brand, up to a 100-day supply when prescribed by plan physician and obtained at a Kaiser pharmacy**	Mail: Refills only; Retail Pharmacy: 100% after \$10 co-pay for generic or \$30 co-pay for brand, up to a 100-day supply when prescribed by plan physician and obtained at a Kaiser pharmacy**	Mail: 100% after \$15 co-pay for generic or \$30 co-pay for brand, up to a 60-day supply; Retail Pharmacy: 100% after \$15 co-pay for generic or \$30 co-pay for brand, up to a 60-day supply when prescribed by plan physician and obtained at a Kaiser pharmacy**
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY	100% for inpatient (short-term treatment only); 100% after \$30 co-pay for outpatient	100% for inpatient (short-term treatment only); 100% after \$30 co-pay for outpatient	100% for inpatient (short-term treatment only) 100% after \$20 co-pay for outpatient up to 20 visits in 2 month period
CHIROPRACTIC	No coverage	No coverage	No coverage

**In accordance with the Kaiser Formulary. Certain drugs are limited to a 30-day supply.

Percentages in the chart reflect the amount the plan pays after the deductible is met, unless indicated otherwise. All pre-existing conditions are covered without restriction.

2004 Health Care Premiums—Semi-monthly

PLAN	EMPLOYEE ONLY			EMPLOYEE+SPOUSE/DP			EMPLOYEE+CHILD(REN)			FAMILY		
	TOTAL	ER*	EE**	TOTAL	ER	EE	TOTAL	ER	EE	TOTAL	ER	EE
SMC POS BCBS	127.75	86.12	41.63	250.50	169.04	81.46	276.00	186.37	89.63	441.00	297.91	143.09
SMC PPO BCBS	127.75	86.12	41.63	250.50	169.04	81.46	276.00	186.37	89.63	441.00	297.91	143.09
CMC POS BCBS	112.00	80.12	31.88	219.75	157.16	62.59	242.25	173.12	69.13	387.00	276.66	110.34
CMC PPO BCBS	112.00	80.12	31.88	219.75	157.16	62.59	242.25	173.12	69.13	387.00	276.66	110.34
CMCC BCBS	112.00	80.12	31.88	219.75	157.16	62.59	242.25	173.12	69.13	387.00	276.66	110.34
Low BCBS	97.50	79.91	17.59	191.25	156.79	34.46	210.75	172.75	38.00	336.75	276.08	60.67
Patient Choice	179.75	78.54	101.21	370.00	154.70	215.30	383.00	169.33	213.67	624.50	272.62	351.88
Kaiser HMO Colorado	115.00	73.75	41.25	227.50	145.25	82.25	248.13	159.00	89.13	395.00	256.00	139.00
Kaiser HMO N. California	93.00	72.92	20.08	186.00	143.87	42.13	201.50	156.37	45.13	322.50	252.76	69.74
Kaiser HMO S. California	93.00	72.92	20.08	186.00	143.87	42.13	201.50	156.37	45.13	322.50	252.76	69.74

*ER = Employer pays
**EE = Employee pays

Prescriptions

Prescription benefits are provided by Express Scripts and coverage is based on the medical plan you choose. To determine the cost implications of your prescriptions under each medical plan, Express Scripts has a helpful online tool called Express Choice. Access Express Choice via the HR site on Trading Post.

Express Choice lets you compare plans side by side:

- Decide which plan is right for you: Compare costs of specific medications under each plan, find participating pharmacies in your neighborhood and view each plan's annual contribution costs.
- Plan your budget: Estimate the prescription costs for everyone under your coverage and set aside the right amount in your Health Care Reimbursement Account.
- Find ways to save money: See how generic drugs and your mail service benefit can save you money and view savings estimates for specific medications.

Additional information about Express Scripts is available in the Important Resources section at the end of this guide.

Transitional Coverage

If you or a covered family member are currently being treated by a provider who does not participate in your 2004 option and treatment is expected to continue into 2004, you or your covered family member may qualify for transitional coverage.

Transitional coverage will allow you to be treated by your current provider for a specified period of time, depending on the situation. Transitional coverage will be available for the treatment of acute conditions, not for the convenience of the member being treated. If you will require transitional care, you must request it in advance by calling the Claims Administrator of the option you elect for 2004. The Claims Administrator can help you through the application process.

If you or a covered family member are pregnant and expects to be in the second or third trimester as of the effective date of new coverage, you/she automatically will be eligible for Transitional Coverage through the first postpartum visit.

You or your family member must still contact your Claims Administrator to request the Transitional Coverage.

If You Waive Coverage

If you waive coverage and you and/or your eligible dependents subsequently lose coverage under another plan, you/they may be eligible for a Health Care Special Enrollment. If you/they qualify, you must complete your enrollment no later than 60 days after the date coverage was lost. (See the Changing Benefit Elections section in the Overview chapter of the Benefits Handbook.)

Identification Cards

For all options, you can expect to receive new ID cards at your home address from your Claims Administrator within two to four weeks following your enrollment. If you are required to select a primary care provider, you may not receive an ID card until you have done so.

In 2004, benefit identification cards will no longer contain social security numbers. Depending on the insurance carrier, either there will be a new alternate employee ID or no ID number on the card.

DENTAL CARE

The Dental Care Program is designed to prevent serious dental problems by encouraging regular dental checkups. All eligible employees may choose from two dental plans: Basic and Premium, which are administered by Delta Dental. Some locations also have a third option, CIGNA Dental Care.

Who is Covered?

You may waive coverage or elect coverage for:

- Yourself only;
- Yourself and your spouse/domestic partner;
- Yourself and your dependent children; or
- Yourself, your spouse/domestic partner and your dependent/domestic partner children.

Basic and Premium

The Basic and Premium options offer a network of dental providers who deliver quality dental care in a cost-effective manner. If you elect the Basic or Premium option, you will minimize your out-of-pocket expenses by using a participating dentist, or you may use a non-participating dentist at a higher out-of-pocket cost.

Starting in January 2004, enrollment in the Premium option requires a commitment of two consecutive years.

PROVISIONS/COVERED EXPENSES	BASIC	PREMIUM
Deductible		
Preventive and Diagnostic Services	\$0	\$0
Basic and Major Services	\$50/person; \$100 family per calendar year	\$50/person; \$100 family per calendar year
Orthodontia	\$0	\$0
Coverage*		
Preventive and Diagnostic	100%	100%
Basic Services	80% after deductible	80% after deductible
Major Services	50% after deductible	80% after deductible
Orthodontia	50%—only for dependent children under age 19	50%—for adults and dependent children
Annual Maximum Benefit Preventive and Diagnostic, Basic and Major Services	\$750/person per calendar year	\$1,500/person per calendar year
Lifetime Orthodontia Maximum	\$750/dependent child per lifetime	\$1,000/person per lifetime

*Percentages shown indicate the percent of the “allowable charge” paid. (See the Payment of Claims section in the Dental Care chapter of the Benefits Handbook for a definition of allowable charge.)

For employees enrolling after Jan. 1 of a given plan year, that partial year will count toward the minimum. You may elect to change whom you cover as dependents from year to year within the Premium option. See the comparison of the Basic and Premium dental options on the table on page 12.

CIGNA Dental Care

CIGNA Dental Care (listed on your Enrollment Worksheet if it is available in your location) is an HMO-type dental health plan that will provide most routine care, such as examinations, X-rays, cleanings, fillings, root canals, oral surgery and extractions at no charge (other than your regular premiums). Major procedures, such as crowns, periodontics, bridgework and orthodontics, will require co-payments.

To receive benefits from the plan, you must select and receive care from a CIGNA Dental Care HMO primary dentist or a specialist referred by your CIGNA Dental Care HMO primary dentist. If you enroll in CIGNA and visit a dentist that does not participate in the CIGNA Dental Care HMO network, your visit will not be covered by the plan. A packet of information on the CIGNA Dental Care option is available by calling HR Direct.

If you elect the CIGNA Dental Care option, you must complete the primary care provider designation form included with your Confirmation Statement and send it to CIGNA. If your completed form is not returned by the enrollment deadline, dental claims may be denied until your form is received. CIGNA has the right to not pay for services or reimburse you for services received prior to receiving and processing your designation form.

Participating Dentists

To determine whether your dentist is a participating dentist, ask the dentist or call your dental Claims Administrator at the telephone number listed in the “Important Resources” section of this guide. If you will be selecting a new dentist, it is recommended that you contact the dentist to see if they are accepting new patients.

Identification Cards

After you enroll in dental care coverage, you will receive a dental plan ID card directly from BCBS-MN Delta Dental. For the CIGNA option, you will receive your identification card at your home address after you have designated the primary care provider. If you do not present your dental identification card, you may need to pay for the services yourself and file a claim for reimbursement.

In 2004 benefit identification cards will no longer contain social security numbers. Depending on the insurance carrier, either there will be a new alternate employee ID or no ID number on the card.

Refer to the Dental Care chapter of the Benefits Handbook for more information.

2004 Dental Premiums—Semi Monthly

PLAN	EMPLOYEE ONLY			EMPLOYEE+SPOUSE/DP			EMPLOYEE+CHILD(REN)			FAMILY		
	TOTAL	ER*	EE**	TOTAL	ER	EE	TOTAL	ER	EE	TOTAL	ER	EE
Basic Delta MN	9.00	4.00	5.00	17.75	8.00	9.75	19.25	8.75	10.50	30.25	14.00	16.25
Premium Delta MN	24.50	4.00	20.50	49.25	8.00	41.25	53.50	8.75	44.75	84.75	14.00	70.75
CIGNA	16.94	4.00	12.94	31.38	8.00	23.38	31.53	8.75	22.78	50.60	14.00	36.60

*ER = Employer pays

**EE = Employee pays

LIFE INSURANCE

Employee Term Life Insurance

If you are a full-time employee, you automatically receive employer-paid Employee Term Life Insurance coverage equal to your Total Benefit Compensation (up to \$200,000). If your Total Benefit Compensation is greater than \$50,000, the cost of your life insurance that exceeds \$50,000 will be imputed as taxable income and federal taxes will be withheld.

You will not need evidence of insurability for Employee Term Life Insurance. If you are a regular part-time employee (scheduled to work 20–29 hours per week), you will not be eligible for Term Life Insurance, but you may choose to enroll in Group Universal Life insurance.

Dependent Term Life Insurance

If you are a full-time employee, you can elect or increase Dependent Term Life Insurance for your spouse/domestic partner and/or eligible children (age 14 days to 25 years). Evidence of insurability will not be required for Dependent Term Life Insurance. You have four Dependent Term Life Insurance options:

- Waive coverage;
- \$5,000 of term coverage on your spouse/domestic partner and \$2,500 on each eligible dependent/domestic partner child;
- \$10,000 of term coverage on your spouse/domestic partner and \$5,000 on each eligible dependent/domestic partner child; or
- \$15,000 of term coverage on your spouse/domestic partner and \$7,500 on each eligible dependent/domestic partner child.

The rate listed for each option on your Enrollment Worksheet is the amount deducted from your paycheck (after-tax) each pay period, regardless of the number of eligible dependents you have. Since all eligible dependents are automatically covered under the level you select, you will not need to designate which dependents you wish to cover or enroll any additional eligible dependents during the year.

You may buy additional coverage for your spouse/domestic partner and/or dependent children through the Group Universal Life (GUL) option. If you are a regular part-time employee, you are not eligible to enroll your dependents in Dependent Term Life Insurance, but you may choose to enroll them in GUL.

DEPENDENT TERM LIFE RATES

Coverage	Employee Rate Per Paycheck
\$5,000 spouse/ \$2,500 children	0.63
\$10,000 spouse/\$5,000 children	1.25
\$15,000 spouse/\$7,500 children	1.88

Group Universal Life (GUL) Insurance

Both full-time regular and part-time employees may apply for GUL insurance.

- You will be able to purchase GUL for up to eight times your Total Benefit Compensation, to a maximum of \$2 million.
- GUL will be available to your spouse/domestic partner for up to eight times your compensation, with a maximum of \$750,000.
- Coverage for your eligible dependent children will be available in two coverage levels: \$5,000 and \$10,000.
- Premiums will be deducted on an after-tax basis.

Because GUL coverage is offered through Minnesota Life Insurance, enrollment for GUL may be completed at any time throughout the year. Information and enrollment will be available via the HR site on Trading Post.

Unlike Employee Term Life or Dependent Term Life Insurance, GUL coverage is portable, which means you will be able to keep your coverage and continue to pay the premiums if you leave Piper Jaffray.

Business Travel Accident Insurance

As a Piper Jaffray employee, you are automatically protected by Business Travel Accident Insurance. Under this plan, you or your beneficiary will receive a benefit if you die or sustain certain injuries as a result of an accident that occurs while you are traveling on Piper Jaffray business. This insurance also pays a benefit if you suffer certain injuries while you are at work.

For 2004, if an eligible injury results in your death, your Business Travel Accident Insurance beneficiary will receive a benefit equal to three times your Total Benefit Compensation, with a minimum benefit of \$200,000 up to a maximum benefit of \$3 million.

DISABILITY

Short-Term Disability (STD)

The Piper Jaffray STD plan is an employer-paid benefit that will replace a percentage of your pay depending on your consecutive months of service if you cannot work due to an approved illness, injury or pregnancy. STD benefits for approved disabilities are covered for a period up to 26 weeks. Coverage will end on your last day of active employment if you terminate your employment, begin severance or began an unpaid leave of absence (except FMLA). Coverage is as follows:

Eligible Classes	Full- or part-time employees working 20 or more hours/week
Eligibility Waiting Period	Three months of employment
Employee Contribution Level	None
Accident/Sickness Waiting Period	1 day/5 days
Benefit Duration	26 weeks
Benefit Percentage	<ul style="list-style-type: none"> ■ Less than 3 months employment—0% ■ 3 months less than 1 year—60% ■ 1 year less than 3 years—80% ■ 3 or more years—100%

Long-Term Disability (LTD)

The LTD plan is an employer-paid benefit that will automatically replace 50 percent of your pay for eligible employees with approved disabilities that extend beyond 26 weeks. During enrollment you may elect to increase your LTD benefit to 60 percent and have a premium deducted from your paycheck (after-tax) each pay period. To be eligible for LTD benefits, you must be actively at work on the date that disability coverage is scheduled to begin. (For most employees this is the beginning of STD.)

If your LTD claim is approved by The Hartford, LTD benefits will begin at week 27 of your disability. Payments generally will continue for as long as you continue to be approved for benefits and comply with all requirements of the plan until you reach age 65, depending on your age when you become disabled. Special limitations on length of benefits will apply to disabilities related to mental illness or substance abuse and those that begin at age 62 and later.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D) insurance provides coverage in the event of accidental death and certain accidental injuries and conditions.

If you are a benefit-eligible employee, you may waive coverage, elect coverage for yourself only (Employee Only) or elect coverage for yourself and your family (Employee Plus Family). If you elect an Employee Plus Family option, you will not need to designate which dependents you want to cover; all eligible dependents are automatically covered. You are the beneficiary of benefits for your covered dependents.

You may purchase AD&D coverage in amounts of \$100,000, \$200,000 and \$300,000; and from \$400,000 to \$1 million in increments of \$100,000 so long as the amount does not exceed 10 times your Total Benefit Compensation. Except in the case of domestic partner benefits, premiums are deducted on a pre-tax basis each pay period.

For example:

- If your Total Benefit Compensation is \$20,000, you may choose AD&D coverage in the amounts of \$100,000 or \$200,000.
- If your Total Benefit Compensation is \$57,500, you may choose AD&D coverage in the amounts of \$100,000, \$200,000, \$300,000, \$400,000 or \$500,000.
- If your Total Benefit Compensation is \$136,000, you may choose AD&D coverage in amounts from \$100,000 to \$1 million in \$100,000 increments.

Refer to the Accidental Death and Dismemberment Insurance chapter of the Benefits Handbook for more information.

AD&D Plan Rates

Plan Coverage	Employee	Family
\$100,000	0.50	0.90
\$200,000	1.00	1.80
\$300,000	1.50	2.70
\$400,000	2.00	3.60
\$500,000	2.50	4.50
\$600,000	3.00	5.40
\$700,000	3.50	6.30
\$800,000	4.00	7.20
\$900,000	4.50	8.10
\$1,000,000	5.00	9.00

The rate listed for each coverage level is the amount deducted from your paycheck each pay period.

Points to consider:

- All LTD options include a cost-of-living adjustment;
- The LTD plan has a pre-existing conditions limitation; and
- You pay your LTD premiums with after-tax dollars; therefore, LTD benefits are generally not regarded as taxable income.

LTD RATES PER PAYCHECK	
Coverage	Employee
LTD 50%	(employer pays)
LTD 60%	
■ Under age 35	0.038
■ 35-39	0.057
■ 40-44	0.090
■ 45-49	0.136
■ 50-54	0.202
■ 55+	0.260

The rate listed for each LTD coverage level is the amount deducted from your paycheck each pay period. Rates per \$100 of covered payroll.

Refer to the Long-Term Disability and Short-Term Disability chapters of the Benefits Handbook for more information.

Carve-Out Long-Term Disability

Employees with Total Benefit Compensation of \$200,000 or above will automatically receive Carve-Out Long-Term Disability coverage of \$7,500. Based on Total Benefit Compensation, employees may be eligible to elect an increase in Carve-Out Long-Term Disability as follows:

CARVE-OUT LTD		
Total Benefit Compensation	Optional Buy-Up Maximum	Rate
■ \$200,000-250,000	\$12,500	31
■ \$250,000+	\$20,000	34

The options you are eligible for will be included on your Enrollment Worksheet. Rates per \$ of covered payroll.

HEALTH AND DEPENDENT CARE REIMBURSEMENT ACCOUNTS

Reimbursement accounts provide you with a money saving way to pay for predictable health care and dependent care expenses (excluding domestic partner expenses). Each year, you will be able to contribute tax-free money from your pay into one or both reimbursement accounts:

- The Health Care Reimbursement Account (HCRA), for eligible, out-of-pocket health and dental care expenses not covered by your health care or dental care plans;
- The Dependent Care Reimbursement Account (DCRA), for eligible expenses for care of your dependents while you (or you and your spouse) work or look for work. (The DCRA cannot be used to pay for your dependents' health care expenses.)

Your contributions to a reimbursement account are pre-tax (tax-exempt), which means they will be free of federal income tax, social security FICA tax and, in some cases, state income tax. As a result, money you would have paid in taxes can instead help you pay for eligible expenses.

During the enrollment period, you decide how much, if any, you want to contribute to your HCRA and/or DCRA. You can elect not to participate, or you can contribute from \$5 per pay period (\$120 annually) to \$208.33 per pay period (\$5,000 annually) to each account. Once you choose to contribute to a reimbursement account, you cannot stop or change the amount you contribute until the next Annual Enrollment unless you qualify for a Family Status Change.

If you participate, you may elect to use ADP's FlexDirect stored value card, which will be automatically updated each pay period with the pre-tax deduction you choose during enrollment. HCRA stored value cards will be loaded with your entire year's allocation. The stored value card may be used for eligible expenses wherever MasterCard® is accepted. Reimbursement will occur automatically each time you use your card. You may also pay for eligible expenses out-of-pocket and file paper claims for reimbursement if preferred. In either situation you should maintain proof of expenses for your files.

According to IRS rules, you will forfeit any funds remaining in your HCRA or DCRA at the end of the year if you have not used them, so it is important to estimate your eligible expenses carefully. To be reimbursed and to avoid forfeiting

your remaining funds, you need to ensure claims for eligible expenses are received by the last business day in March following the end of the plan year.

Your reimbursement account contributions will affect the amount you can deduct for health care and dependent care expenses on your federal tax return, so you may want to check with your tax advisor to see what works best for you.

THE TRANSPORTATION PROGRAM

The Transportation Program helps you manage your transportation expenses through two options:

- The Transit Reimbursement Account allows you to use pre-tax dollars to reimburse yourself for work related mass transit expenses. You can elect not to participate or you can contribute from \$5 to \$50 per pay period to this account. You are not eligible for this program if you currently participate in a transit program in your area;
- The Parking Reimbursement Account allows you to use pre-tax dollars to reimburse yourself for work related parking expenses. You can elect not to participate or you can contribute from \$5 to \$95 per pay period (or \$2,280 per year) to this account.

You can enroll in the Transit and Parking Reimbursement programs either during Annual Enrollment or at a later date. You may also change your contribution amounts at any time.

If you participate, you will receive ADP's FlexDirect stored value card, which will be automatically updated each pay period with the pre-tax deduction you choose during enrollment. The stored value card may be used for eligible expenses wherever MasterCard® is accepted. Reimbursement will occur automatically each time you use your card. You may also pay for eligible expenses out-of-pocket and file paper claims for reimbursement if preferred. In either situation you should maintain proof of expenses for your files.

Refer to the Transportation Program chapter in the Benefits Handbook for more information about eligible expenses for these accounts.

PAID TIME OFF

Piper Jaffray provides full-time, non-commissioned and regular part-time employees with annual Paid Time Off (PTO). Commissioned employees are not eligible for PTO. PTO days may be used for vacation, personal time, illness, time off to care for dependents or attend school conferences for your children. Time off should be scheduled in advance and approved by your supervisor, except in cases of illness or emergency. Firm holidays, time off for jury duty or bereavement leave are not included in PTO.

PTO is based on your years of service, salary grade or officer title, and standard hours of work each calendar year. On the first day of work in January, you will be allocated PTO according to the schedule below. Your years of service is determined by looking at your next anniversary within the year. Although PTO is allocated on your first day of work, it is earned during the year at a rate of 1/12th of the allocated amount for each month of service.

The 2004 PTO schedule will be based on the 2003 vacation schedule with the addition of seven days, to account for six sick days and one floating holiday. Additional PTO days may not be purchased; however, you may carry-over five days from the prior year to be used by March 31 of the following year*. After March 31, any unused carry-over will be forfeited.

Following is the PTO schedule for 2004:

Length of Service	Grades 7-9 ⁽¹⁾ /A-G	Grades 10-13 ⁽²⁾ /H-I	Grades 14+ ⁽³⁾
1-4	17 Days	22 Days	27 Days
5-9	22 Days	22 Days	27 Days
10-14	22 Days	27 Days	27 Days
15-24	27 Days	27 Days	27 Days
25+	32 Days	32 Days	32 Days

- (1) Non-commissioned employees who are ungraded and without an officer title will follow the Grades 7-9 guidelines.
- (2) Non-commissioned employees who are ungraded with an assistant vice president title will follow the Grades 10-13 guidelines.
- (3) Non-commissioned employees who are ungraded with a vice president title or above will follow the Grades 14+ guidelines.

Refer to the Time Away From Work chapter in the Benefits Handbook for more information about time away from work.

*Employees in California will be able to carry-over 75 percent of their current accrual schedule and will be capped at 1.75 percent of their current schedule. Employees in California will not forfeit PTO carried over from the previous year but will not continue to accrue PTO beyond the cap.

HOW TO ENROLL

You may enroll for benefits online or by submitting a completed Enrollment Worksheet.

Online enrollment will be completed via My HR Info employee self-service on Trading Post. My HR Info provides password-secured access to your benefits information (though you must be logged on to the Piper Jaffray network).

The Enrollment Worksheet you receive during your enrollment period may also be used as your enrollment form to make benefit elections. Complete your worksheet and mail it via interoffice mail to Human Resources, J1012551 (in 2004 mail to J09S03).

Before You Enroll

Review Your Enrollment Worksheet

Home address, date of birth and the Total Benefit Compensation indicated on your Enrollment Worksheet are used to determine your benefit options and premiums. If any of this information is incorrect, please call HR Direct immediately.

Review Your Dependent Information

If the dependent information on your Enrollment Worksheet is incomplete or incorrect or if you need to add your spouse and/or dependent children, you must make the appropriate changes to your Enrollment Worksheet online via My HR Info or by calling HR Direct prior to enrollment.

Further, if you are enrolling a domestic partner or dependents of your domestic partner who previously were not enrolled in your benefits, please call HR Direct before the enrollment deadline.

When You're Ready to Enroll

Make your Benefit Decisions

Review and complete your Enrollment Worksheet. Your worksheet contains the options for which you are eligible and the benefits requiring enrollment. It is designed to help you prepare for the enrollment process. If you have questions about your benefit options, refer to the Health Care Option Comparisons in this guide, the October 2003 issue of HR Guide, and/or the summary plan description(s) for the applicable benefits.

Online Enrollment

- Log on to My HR Info through Trading Post.
- On the Trading Post home page select Human Resources.
- Select My Employment, and then My HR Info.
- Enter your 6-digit employee number (e.g., Exxxx) and PIN.
- Once you have signed in, a list of benefit links will be available in the left-hand menu.
- Scroll down the Enroll In Benefits page to view your Enrollment Summary information. Please note: You will need to make an election for each option, even if waiving coverage. If you do not make an election you will not be able to complete the enrollment process.
- When you've selected your desired benefit options, click Finish Enrollment on the Benefits Enrollment page and wait for the Submit Confirmation page to appear before you log off or go to another site. If the Submit Confirmation page does not appear, your elections have not been saved and you will need to start again.

If your choices have been saved, My HR Info will summarize your benefit elections, disclose the impact of your elections on your pay and allow you to print a temporary confirmation. You may end your session after seeing this information. You will receive a Confirmation Statement verifying your elections in the mail after you enroll. Review this confirmation and complete any additional outlined steps by the deadlines to complete your enrollment.

Your PIN

If you have never logged in to My HR Info, your PIN is the last four digits of your social security number. After your initial log on, you will be prompted to change your PIN. If you require password/PIN support, call the Service Center at 612 303-8000.

Paper Enrollment

The Enrollment Worksheet you receive during your enrollment period may also be used as your enrollment form to make benefit elections. Complete your worksheet and mail it via interoffice mail to Human Resources, J1012551 (in 2004 mail to J09S03). You will need to sign and date your enrollment form.

After You Enroll

Verify or Change Your Elections

After you have processed your enrollment, you can verify or change your elections before the enrollment deadline. Once the deadline has passed, you may not change your elections for most benefits (including the Default Program), unless you qualify for and complete a Family Status Change or Health Care Special Enrollment.

To verify or change your elections online, follow the same steps as outlined in the When You're Ready to Enroll section of this guide.

Confirmation Statement and Additional Forms

An online Confirmation Statement showing your benefit elections will be available for review immediately on My HR Info after entering your elections. Additionally, a confirmation will be mailed to you shortly after you complete your online or paper enrollment.

Review your statement to ensure that it accurately reflects your elections. You can make changes up until the enrollment deadline. If you change your elections during the enrollment period, a new Confirmation Statement will be mailed to you, or you may print one after entering your changes online.

If you enroll for benefits using your Enrollment Worksheet, you will be able to make changes prior to the deadline on My HR Info after you receive your initial Confirmation Statement.

You will not be able to make changes until the next Annual Enrollment once the deadline has passed, unless you qualify for and complete a Family Status Change form or Health Care Special Enrollment.

You will receive a Confirmation Packet two weeks after completing your enrollment. Your confirmation packet will

contain any additional information and/or forms based on the elections you made.

If you need to take any additional action, instructions will be provided. If you fail to take the necessary action, such as selecting a primary care provider, your providers may not be able to verify coverage, and you may not have coverage immediately and/or your claims may be denied. Compare your Confirmation Statement to your Jan. 15, 2004, pay advice to ensure that your deductions are accurate.

For More Information

Benefits Handbook

Summary plan descriptions (SPDs) provide detailed information regarding eligibility, coverage, processes and more about your benefits. Please access SPDs for the benefits you intend to elect in one of the following ways:

- View in your work area. Printed copies of the 2004 SPDs (distributed to managers and supervisors) are maintained in an accessible workplace location for your reference.
- View or print online. From the Human Resources site on Trading Post, select the Benefits link and then select the link for the SPD you wish to access.

HR Guide

The October 2003 issue of HR Guide provided information about 2004 benefits options and changes, as well as helpful planning tools and resources. Refer to the print copy you received via interoffice mail or access HR Guide on the HR site on Trading Post.

Provider Directories

You may access online provider directories—listing the eligible providers/doctors in your area—at the Web site of the applicable Claims Administrator. Links to provider directories will be available on the HR site on Trading Post.

Group Universal Life (GUL) Insurance Enrollment Information

Minnesota Life Insurance, the administrator for GUL, will send a letter (separate from the Piper Jaffray benefits enrollment materials) in late October to eligible employees who currently are not enrolled in GUL with instructions for enrolling either online or through a toll-free automated phone line.

IMPORTANT RESOURCES**HR Direct**

Piper Jaffray HR representatives are available Monday through Friday (except holidays),
7:30 a.m. to 5:00 p.m. (Central Time)

612 303-6246
888 HR PIPER, 888 477-4737

My HR Info

Employee self-service for Piper Jaffray employees to manage personal information,
view pay history and enroll for benefits

Trading Post
HR site

ADP Reimbursement Accounts

Health Care, Dependent Care and Parking Reimbursement Accounts and Transit Plan

800 654-6695
flexdirect.adp.com

Blue Cross and Blue Shield of Minnesota

Group Number: Check your ID card
Consumer Managed Care, Standard Managed Care,
Consumer Managed Care Comprehensive, Low Plans
Twin Cities Metro Area
Outside Twin Cities Metro Area
TDD* Twin Cities Metro Area
TDD* Outside Twin Cities Area

651 662-5730
866 537-7730
651 662-8700
888 878-0137
www.bluecrossmn.com

BluePrint for Health® Care Support**Disease Management**

Resources and support for employees and their family members living with diabetes or cardiac disease

888 264-1744

24-hour nurse line

877 993-6287
877 993-6287

Healthy Start Pregnancy Program

Resources and supports employees or family members during pregnancy

651 662-1818
800 382-2000, ext. 21818

CIGNA Dental Care

Group Number: 3310996
Enrolled Members

800 367-1037
www.cigna.com
www.mycigna.com

Delta Dental Plan of Minnesota

Group Number: 50800
Twin Cities Metro Area
Outside Twin Cities Metro Area

651 406-5901
800 448-3815
www.deltadentalmn.org

Express Scripts

Prescription drug provider for medical options administered by Blue Cross and Blue Shield of Minnesota
TDD*
Eligibility, Claims Information, Mail Service
Online Pharmacy Benefits Comparison

866 576-3866
800 305-5376
www.express-scripts.com
www.member.express-scripts.com/choice/PiperJaffray

The Hartford Benefit Management Services

Short-Term Disability Program, Group Number: GRH070635
Long-Term Disability Program, Group Number: GRH070636

888 707-5333

Hartford Life Insurance Company

Accidental Death and Dismemberment Insurance, Group Number: ADDS01063
Business Travel Accident Insurance, Group Number: ETB-17173

888 563-1124 options 843, 4877
to check on the status of a claim only

Kaiser Option—Colorado

Group Number: 22314

303 338-3800 or 800 632-9700
www.kaiserpermanente.org

Kaiser Option—Northern California

Group Number: 600398

800 464-4000
www.kaiserpermanente.org

Kaiser Option—Southern California

Group Number: 227275

800 464-4000
www.kaiserpermanente.org

Minnesota Life—Term and Group Universal Life (GUL)

Employee and Dependent Term Policy Number: 32875
GUL Policy Number: 50167

800 843-8358
Fax: 651 665-4827

Patient Choice

Group Number: 76-030065
Patient Choice Helpline—Medical Benefits
Online Provider Directory
Online Eligibility, Claims Information, etc.
Express Scripts, Inc. Helpline—Prescription Benefits

877 390-7632
www.patientchoicesignature.com
www.wausaubenefits.com
888 518-2589
www.member.express-scripts.com

*Telecommunications Device for the Deaf

