

SUMMARY PLAN DESCRIPTION

HOPE COLLEGE EMPLOYEE BENEFIT PLAN

This Summary Plan Description includes various booklets furnished by the Plan's third party administrator, and insurance companies that explain your benefits in more detail. Please read these booklets and this Summary Plan Description carefully. If you have any questions regarding the Plan, contact the Human Resources Department.

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PLEASE NOTE

ALL DECISIONS REGARDING HEALTH CARE ARE UP TO YOU AND YOUR DOCTORS.

THIS SUMMARY PLAN DESCRIPTION AND BOOKLETS ATTACHED OR PREVIOUSLY DISTRIBUTED DESCRIBE THE CIRCUMSTANCES UNDER WHICH THE PLAN WILL **PAY** FOR CERTAIN TREATMENT. IF YOU AND YOUR DOCTORS DETERMINE THAT SPECIFIC TREATMENT IS APPROPRIATE, AND THE **COST** OF THAT CARE IS NOT COVERED BY THIS PLAN, YOU MAY OBTAIN TREATMENT AT YOUR OWN EXPENSE. THIS APPLIES TO MEDICAL TREATMENT FOR YOU AND YOUR DEPENDENTS.

SUMMARY PLAN DESCRIPTION

HOPE COLLEGE EMPLOYEE BENEFIT PLAN

We maintain the Hope College Employee Benefit Plan to provide health care and other welfare benefits for our eligible employees and to pay their share of the cost of benefits on a pre-tax basis under Code Section 125. We will refer to the Hope College Employee Benefit Plan as the "**Plan**" throughout this Summary. The terms "**we**," "**us**," "**our**" and "**College**" refer to Hope College.

Eligible employees will receive the benefits described in the section titled **BENEFIT PROGRAMS**. The method of paying for the benefits you select and the tax consequences of your selections are described in the section titled **FLEXIBLE BENEFIT FEATURES**.

This is a summary of the Plan as amended through January 1, 2009. We are responsible for administering the Plan in accordance with the plan document. The Plan is operated on a "**plan year**" basis. The plan year is the 12-month period ending on June 30 each year beginning on July 1, 2008.

The terms and conditions of the Plan are contained in written plan documents and in insurance contracts, insurance certificates, and program booklets. In general, the materials for the programs that are self-insured have been prepared by the third-party administrator (TPA). The insurance contracts and certificates have been prepared by the insurance carriers that administer the insured benefit programs. Together, these documents describe your benefits in detail, and they are incorporated in and made a part of this Summary Plan Description (incorporated materials). This Summary Plan Description will not enlarge or modify any benefits described in the incorporated materials.

If you have any questions regarding your eligibility for or the amount of any insured benefit payable, contact the appropriate insurance company. If you have any general questions regarding the Plan, your eligibility for coverage, or the amount of any self-insured benefit payable, contact the Human Resources Department. The programs that are insured and insurance carriers providing those benefits and the self-insured benefits and the TPA administering them are listed at **GENERAL INFORMATION**.

In the event of any conflict between this Summary Plan Description and the incorporated materials providing these benefits, the incorporated materials will control.

PARTICIPATION

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

All "**full-time**" employees, except those listed below, are eligible to participate in the Plan on their date of hire. A full-time employee is an employee who is regularly scheduled to work 1365 or more hours per year.

Certain retired employees are eligible to participate in the hospitalization and basic medical care coverage provisions of the Plan following their retirement. The terms of the eligibility and the retiree share of the cost are described in the Exempt Administrative Employee Handbook, Hourly Employee Handbook or Faculty Handbook.

WHO IS NOT ELIGIBLE TO PARTICIPATE IN THE PLAN?

Participation is limited to employees. However, the following employees are not eligible to participate in the Plan:

- Employees who normally work six (6) months or less per year;
- Employees who are not citizens of the United States, who reside and are employed outside the United States, and whose compensation from the College does not constitute income from sources within the United States;
- Employees who perform services for us pursuant to an agreement between us and another person or entity, such as an employment agency or an employee leasing organization;
- Students performing services for the College;

- Employees who perform services for us pursuant to a written agreement with us that does not provide for participation in the Plan;
- Employees in grant-funded positions unless the terms of the grant provide for benefit plan coverage;
- Lecturers who are not classified as professors, associate professors or assistant professors;
- Faculty members on sabbatical leave except to the extent they continue to receive compensation from the College while they are on leave; and
- Visiting faculty members (unless participation is required by contracts between the visiting faculty members and the College).

WHEN ARE YOU ELIGIBLE TO PARTICIPATE IN THE SPECIFIC PROGRAMS?

Generally, you will become a participant in the specific programs on the day you meet the eligibility requirements for the programs and file appropriate election forms with the Human Resources Department. You must file an election form each year to continue to participate in many of the programs of the Plan.

WHEN DOES PLAN PARTICIPATION TERMINATE?

- ***Participation Terminates***

Except as described below or as described in the booklets for the specific programs, your participation under this Plan will cease on the day:

- You no longer meet the eligibility requirements for participation due to retirement (except as described below), cessation of active employment, reclassification, reduction in hours, leave of absence (other than FMLA) or any other reason;

- Your election for benefits is no longer in effect;
- You fail to make your required contributions under this Plan; or
- You submit fraudulent claims or otherwise abuse the benefits under the Plan (including misrepresentation of citizenship or immigration status in obtaining or maintaining employment).

Your spouse and other dependents will lose coverage at the same time you lose coverage. Your spouse and other dependents will also lose coverage on the day they no longer meet the dependent eligibility requirements under the Plan.

- ***Participation Upon Reemployment***

If your employment terminates, your participation in the Plan terminates as described above. On re-employment you must again satisfy the service requirements for each benefit program, unless you are re-employed within 30 days. If your re-employment occurs within 30 days, your prior elections will be reinstated. If re-employment occurs after 30 days, you must satisfy the eligibility requirements and make new elections.

- ***Retirement***

Employees who terminate employment after attaining age 60 and completing 10 years of full-time service are eligible to continue their health care coverage until attaining age 65 on payment of 100% of the premium cost. Faculty and staff eligible for early retirement continue their participation on the same basis as active employees. Faculty and staff who terminate employment who retire with 10 years of full-time service after attaining age 65 or who retired under the early retirement program may participate in the Medicare Advantage Program by paying 100% of the premium. Faculty and staff hired before June 1, 1995 are eligible to receive greater College subsidy amounts. The retiree policy is described in greater detail in the Exempt Administrative Employee Handbook, Hourly Employee Handbook and the Faculty Handbook.

- ***Disability***

Employees who terminate employment due to disability and qualify for long-term disability coverage may continue their coverage on the same basis as active employees for a period not greater than the number of years of active service with the College.

WHAT HAPPENS IF YOU ARE ON A LEAVE OF ABSENCE OR LAYOFF?

- ***FMLA Leave***

If you are on a leave of absence under the Family and Medical Leave Act ("**FMLA leave**") you may continue your health care coverage and medical expense reimbursement coverage under the Plan during FMLA leave. Your coverage and costs will be the same during the leave as the coverage and cost for similarly situated active employees who are not on FMLA leave.

If you chose to continue your coverages during your unpaid leave, you may:

- Pay your share of the premium payments on the same schedule as payments are made for COBRA continuation on an after-tax basis;
- Arrange with the Human Resources Department to make catch-up payments when you return; or
- Prepay your share of the cost of benefit plan coverage on a pre-tax basis.

If you fail to pay any portion of your costs within 30 days of the due date, your coverage will terminate retroactive to the first day of the coverage period for which payment is unpaid. We will notify you of nonpayment 15 days prior to the expiration of the 30-day grace period. If we choose to continue your coverage, we are entitled to collect unpaid amounts from you after you return from FMLA leave.

If you let your medical expense reimbursement account lapse during the unpaid leave, you may reinstate coverage for the remaining part of the plan year when you return. However, the expenses you incur during the lapse will not be reimbursable and you may elect to reduce the maximum

reimbursement amount proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and you are out on leave for two (2) months and you let coverage lapse, your amount will be reduced to \$1,000. Alternatively, you may elect to resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments.

Your full participation in the Plan will be reinstated upon your return to work prior to or upon termination of unpaid FMLA leave. If you do not return to work from FMLA leave for any reason other than the continuance, recurrence, or onset of a serious health condition, we may recover from you any College contribution paid to the Plan to maintain your coverage during your leave. You will be eligible to elect continuation of health care benefits under COBRA at the termination of FMLA leave if you do not return to eligible participant status.

For any portion of your FMLA leave that is paid leave and you do not revoke or suspend your health coverage, you will continue to pay the required cost of coverage, in the same manner as prior to the FMLA leave (pre-tax payroll deduction). A leave is "paid" during the portion of the leave during which you continue receiving your salary or hourly wage, payment for unused vacation or sick time, or any self-insured short-term disability income or salary continuation benefits from the College. Medical expense reimbursement premiums will be paid during the paid leave in the same manner as payments are made while on unpaid leave.

If your non-FMLA leave is paid you will continue paying your share of the cost of benefits on the same basis as for health care benefits that are continued during a paid FMLA leave.

The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by the College). However, if a participant takes a leave under FMLA to care for a spouse, parent, child or next of kin injured in the line of active military duty, the maximum period of FMLA leave is 26 weeks per 12-month period.

- ***Other Leaves of Absence or Layoff***

If you are on a non-FMLA authorized leave of absence or a temporary layoff, you will not be eligible to participate in the Plan during the layoff or leave unless the terms of the layoff or leave provide for continued participation.

If the leave or layoff provides for continued participation, you must pay your share of the premiums to continue your coverage under the Plan. If you do not pay any employee portion of the premium within 30 days of the due date, your coverage under the Plan will be terminated. The termination will be retroactive to the premium due date.

- ***All Leaves***

All periods of approved leave, including FMLA leave, will run concurrently. Your participation in the Plan will cease at the end of the period of continuation, if any, or the cessation of the condition for which the leave was granted, whichever occurs first.

BENEFIT ELECTIONS

HOW DO YOU ELECT TO PARTICIPATE?

Except as described below, you must complete and file *election forms* with the Human Resources Department before the date you first become eligible to participate in the Plan and during each annual open enrollment period. You must also file enrollment forms provided by the TPAs or insurance companies for some of the benefit programs offered under this Plan.

You may elect the following benefits:

- ***Hospitalization and basic medical coverage and persons covered***
- ***Voluntary dental care coverage only and persons covered***
- ***Optional dependent life insurance***
- ***Additional supplemental life insurance for yourself***
- ***Optional additional long-term disability insurance coverage***
- ***Medical expense and dependent care expense reimbursement***

If you become eligible on your first day of employment, you must complete and file an election form and enrollment forms within 30 days of your date of employment. However, salary reduction amounts used to pay for your benefit may only be taken from compensation that becomes available after your election. If your employment terminates and you return to employment within 30 days after terminating (or you return from an unpaid leave of absence of less than 30 days) you will not be treated as a new employee for purposes of this paragraph and elections that you must file on your return, if any, will operate prospectively.

Your election to participate and your level of coverage (single, family, etc.) in the hospitalization and basic medical, voluntary dental plans and your elections for additional supplemental participant or optional dependent life insurance and optional additional long-term disability insurance will not be automatically renewed from year-to-year. Your elections for those benefits must be renewed or revised during each year's open enrollment period.

BENEFITS YOU RECEIVE IF YOU DO NOT FILE AN ELECTION FORM

If you are an eligible full-time employee and you do not file an election form and complete any required enrollment forms, you and your dependents will not be eligible for any elective benefits under the Plan. You will be eligible for the employee assistance program, basic long term disability insurance, and basic life insurance.

CAN YOU WAIVE HEALTH CARE COVERAGE?

We have adopted this Plan so that all eligible employees will have comprehensive health care coverage. But if you have hospitalization and basic medical coverage through another source, you may waive the College's hospitalization and basic medical coverage.

HOW DO YOU CHANGE YOUR ELECTION DURING THE ANNUAL ENROLLMENT PERIOD?

You may change your election each year during the "**annual open enrollment**" period by filing a new election form. The annual open enrollment period is a period of at least 30 days beginning not earlier than April 15 and ending not later than June 30. Elections go into effect on July 1 following each annual open enrollment period.

HOW DO YOU CHANGE YOUR ELECTION DURING THE PLAN YEAR?

Generally, you cannot change your election to participate in the Plan or change your contributions or the benefits you have elected during the plan year. Following are several important exceptions to this general rule:

- ***Change in Status Events.*** The following are considered changes in status if the event results in the gain or loss of eligibility under the Plan or a similar employee benefit plan and the election change corresponds with that gain or loss of coverage:
 - A change in your legal *marital status*, such as marriage, legal separation, annulment, divorce, or death of your spouse;
 - A change in the *number of your dependents*, such as birth of a child, adoption or placement for adoption of a dependent, or death of a dependent;
 - A change in your *employment status* or that of your spouse or dependent that affects eligibility for coverage under the Plan, or a spouse's or dependent's plan, including a termination or commencement of or return to employment, a commencement of or return from an unpaid leave of absence, or a change in work schedule or worksite provided, however, that a participant may not increase benefits on account of a change in employment status due to the participant's reduction in hours, layoff or termination of employment and may not change an election if the absence is less than 30 days;
 - A change in eligibility for *dependent status* causing a dependent to satisfy or to cease satisfying coverage requirements due to age, student status, marriage or similar circumstances; and
 - A change in your *residence* or the residence of a spouse or dependent if the change affects eligibility for coverage.
- ***Change in Status – Other Requirements.*** If you wish to change your election based on a change in status, you must establish that the change in your election is on account of and corresponds with the change in status.

Generally, a desired election change is found to be consistent with a change of status event if the event affects coverage eligibility. You must also satisfy the following specific requirements:

- *Health care programs and medical expense reimbursement benefits:* You may change your election only if the change in status results in becoming eligible or ineligible for the benefit or a particular benefit option under the Plan (or your spouse or dependent's plan), and your election change corresponds with the gain or loss of coverage.

You may drop or decrease your coverage on account of a change in status, but you may not add or increase coverage unless the change in status is also a special enrollment event and permitted under the terms of the health care programs.

- *Disability, Life and AD&D insurance.* If you have a change in status event, you may elect to either increase or decrease coverage even if the change does not affect eligibility.
- *Dependent care reimbursement.* You may change your election only if the change is consistent with a change in status that affects eligibility for coverage under the Plan or eligibility of dependent care expenses for the available tax exclusion. A change in dependent care provider is a change in coverage for purposes of this Plan.
- ***Special Enrollment Events.*** You have a special enrollment event for the health care programs if:
 - You acquire a dependent through marriage, birth, adoption or placement of a child with you for purposes of adoption; or
 - You declined health care program coverage under the Plan for yourself or eligible dependents because you or your dependents were covered under another group health plan or you or your dependents had other group health coverage ("other coverage") as these terms are defined in HIPAA and you or your dependents lose that other coverage.

If you have a special enrollment event you may elect coverage under the health care programs for yourself and your eligible dependents if the following requirements are met:

- When you were previously offered coverage you declined coverage *in writing* because you or your dependents had other coverage;
- You request enrollment within 30 days of the loss of other coverage and provide proof of loss of the other coverage; and
- Either the other coverage was COBRA continuation coverage and it ran out or the other coverage was not COBRA continuation coverage and it ended because you lost eligibility or the employer stopped making contributions.

Retirees are not eligible to add coverage due to Special Enrollment events.

You do not have a special enrollment even if you lose coverage due to the following circumstances:

- You do not pay your premiums on a timely basis;
- You choose to drop coverage for any reason, including premium increase or a benefit change; or
- Your coverage was terminated for cause, such as making a fraudulent claim or giving false information.

Retirees and other participants who are former employees are not eligible to add coverage due to Special Enrollment Events.

- ***Certain Judgments and Orders.*** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your child to be covered under this Plan, you must change your election to add healthcare coverage for this child. If the order requires another individual (such as your former spouse) to cover the child, you may change your election to revoke coverage for the child if the other coverage is actually provided.

- ***Entitlement to Medicare or Medicaid.*** If you, your spouse, or a dependent become entitled to Medicare or Medicaid, you may cancel that person's health coverage.
- ***Change in Cost.***
 - If we notify you that your share of the cost of your coverage under the Plan is *significantly* changing during the plan year, you may choose either to make an increase in your contributions or to revoke your election and receive coverage under another Plan option that provides similar coverage or drop coverage if no similar coverage is available.
 - For *insignificant* changes in the cost of benefits, however, we will automatically adjust your contribution elections to reflect the minor change in cost.

You may change your dependent care expense election but not your medical expense reimbursement election as a result of a change in cost.

- ***Change in Coverage.***
 - If your coverage under the Plan is significantly reduced, you may revoke your election and elect coverage under another Plan option by making a corresponding election change under another option that provides similar coverage;
 - Additionally, if the Plan adds or eliminates a coverage option, you may elect the newly added option or elect another Plan option (when a Plan option has been eliminated), and may do so on a pre-tax basis by making a corresponding election change under another Plan option that provides similar coverage, if any; or
 - If the coverage reduction is so significant that it is a loss of coverage, you may drop coverage if no similar benefit package is available.

You may change your dependent care expense election but not your medical expense reimbursement election as a result of changes in coverage. E.g. You may change your dependent care expense election if you change daycare providers, but you may not change your medical expense reimbursement election if you change doctors.

- ***Change in Coverage under Another Employer's Plan.*** You may make an election change that is consistent with a change made under the employer plan of your spouse, former spouse, or dependent if:
 - The other employer's plan permits its participants to make a change; or
 - The period of coverage under this Plan is different from the period of coverage under the other employer's plan.

You may change your dependent care expense election but not your medical expense reimbursement election as a result of changes under another employer's plan.

To make a change, you must file a written request for change with the Human Resources Department within 30 days of the event permitting the change. If you wait longer than 30 days, you will not have the opportunity to change your elections until the next open enrollment period. No mid-year change is permitted under the medical expense reimbursement program that decreases the contributions for the plan year to an amount that is less than the medical expenses incurred by the participant and beneficiaries prior to the date of the revised election. All changes are prospective from your date of notification, except changes involving the birth, adoption, or placement for adoption of a child, which will be retroactive if made within the 30-day requirement. Even though one of the above events occurs, your ability to change may be limited by the program or insurance company terms. We may also change your elections during the plan year to satisfy legal requirements.

The change in status exceptions are complex. If you would like to change an election during a plan year, please contact us for more information.

FLEXIBLE BENEFIT FEATURES

EMPLOYEE PRE-TAX CONTRIBUTIONS

- ***Pre-tax Premium Payments***

We provide benefits only to eligible employees who elect to participate and agree to contribute their share of the cost. We will announce your cost for these benefits prior to the beginning of each plan year and when cost changes occur during the year. Except for the cost of additional supplemental life insurance coverage on your life and optional dependent life insurance, you will pay your portion of the premiums with *pre-tax* contributions. Your share of the premiums is paid through payroll deductions in approximately equal installments during the plan year.

- ***Reimbursement Accounts***

This Plan also allows you to contribute part of your compensation on a *pre-tax* basis to two (2) reimbursement accounts available to you:

- *Medical Expense Reimbursement Account* that you can use to pay for eligible medical care expenses.
- *Dependent Care Reimbursement Account* that you can use to pay for eligible dependent care expenses.

The amounts that you elect to contribute to these accounts will be paid by payroll deductions during the year in approximately equal installments on a pre-tax basis. You may not carry over unused funds in your medical expense or dependent care expense reimbursement accounts into periods after the plan year for which the election was made or transfer money from one account to another. Since federal law requires you to use all the amounts in your reimbursement accounts during the plan year you must be very careful in determining the amount to be allocated to each of your accounts. **If you do not submit claims up to the amounts that you elected for the plan year, then any remaining amounts in your accounts**

90 days after the earlier of the plan year or your termination of employment will be forfeited and used to offset losses during the plan year as a result of making reimbursements to participants in excess of contributions, to pay administrative expenses of the Plan, or revert to the College.

The amounts you allocate to your reimbursement accounts may not be changed during the plan year unless you have a change described in **HOW DO YOU CHANGE YOUR ELECTION DURING THE PLAN YEAR?** More information about reimbursement accounts is described in **BENEFIT PROGRAMS.**

HOW DOES PARTICIPATION IN THE PLAN AFFECT YOUR TAXES?

- ***Income Taxes***

The pre-tax premium payment and reimbursement account features of the Plan can help you reduce your taxes and increase your spendable income. The amounts you contribute to the Plan are placed in your premium payment and reimbursement accounts before taxes are taken out. These amounts are not counted in your taxable income and are not reported on your W-2 form. This keeps your benefit costs low and can even result in a net increase in spendable income. This can be illustrated by the following example:

| | <u>With Your Plan</u> | <u>Without Your Plan</u> |
|------------------------|----------------------------------|-------------------------------------|
| Gross Taxable Wages | \$30,000 | \$30,000 |
| Pre-tax Contribution | <u>1,800</u> | <u>N/A</u> |
| Taxable Wages | \$28,200 | \$30,000 |
| Estimated Taxes* | 3,165 | 3,553 |
| After-tax Contribution | <u>N/A</u> | <u>1,800</u> |
| Take-home Pay | <u>\$25,035</u> | <u>\$24,647</u> |

**Assumptions:* Married couple; two children; joint return; 10% federal income tax rate; 3.9% state income tax rate; 7.65% FICA tax rate; no non-wage income; and before tax credits and other adjustments.

By paying for benefits before taxes are calculated, estimated taxes are reduced by approximately \$388, which is over \$32 per month more in take-home pay in our example. Your savings may be greater if your marginal income tax rate is higher.

- ***Social Security Taxes***

If you pay your share of the premium or pay for any benefits using pre-tax dollars, the amount of your Social Security taxes will be reduced. This means your Social Security benefits may also be reduced at retirement.

EMPLOYEE AFTER-TAX CONTRIBUTIONS

We provide certain benefits only on an after-tax basis. These include optional dependent life insurance and the cost of optional supplemental life insurance for coverage on your life. The College will announce your cost of these benefits prior to the beginning of each plan year. You pay your portion of the premium for these benefits with *after-tax* compensation. Your share of your premiums is paid through payroll deductions in approximately equal installments during the plan year.

BENEFIT PROGRAMS

HEALTH CARE PROGRAM

The Plan provides self-insured hospitalization and basic medical care coverage (medical coverage) to eligible employees. You may choose between the "Blue" options offering greater coverages and lower deductibles at a higher employee cost or the "Orange" option offering a lower level of coverage and with higher deductibles, but with a lower employee cost. The booklet attached or previously distributed explains this program.

You may also elect the insured voluntary dental program. The booklet attached or previously distributed explains this program.

The booklets or certificates for the health care programs will provide the following information:

- Any deductibles, co-insurance or co-payment amounts, annual or lifetime caps or other limits on benefits;
- Coverage of preventative services;

- Whether and under what circumstances prescription drugs are covered;
- Whether and under what circumstances medical tests, devices and procedures are covered;
- The use of network providers and the composition of the provider network;
- Whether and under what circumstances out-of-network services are covered;
- Conditions or limits on the selection of primary care providers or providers of speciality medical care;
- Conditions or limits to obtaining emergency medical care;
- Any requirements for pre-authorization review as a condition to obtaining a benefit or service;
- A summary of claim procedures.

LIFE INSURANCE PROGRAM

- ***Basic Life Insurance***

The Plan provides basic life and accidental death & dismemberment (AD&D) insurance benefits to eligible employees. The booklet attached or previously distributed explains this program.

- ***Additional Supplemental Participant***

Participants have the option to purchase additional supplemental participant life insurance under the Plan. The booklet attached or previously distributed explains this program. You pay the entire cost of this coverage on an after-tax basis.

- ***Optional Dependent Life Insurance***

The Plan also provides participants the option to purchase optional dependent life insurance for their spouse or dependent children. The booklet attached or previously distributed explains this program. You pay the entire cost of this coverage on an after-tax basis.

LONG-TERM DISABILITY PROGRAM

- *Basic Long-Term Disability Insurance.*

The Plan provides basic long-term disability benefits for eligible employees. Your long-term disability benefit begins after six (6) months of disability. The booklet attached or previously distributed explains this program.

- *Optional Additional Long-Term Disability Insurance.*

Participants also have the option to purchase optional additional long-term disability insurance under the Plan. The booklet attached or previously distributed explains this program. You pay the entire cost of this coverage on an after-tax basis.

MEDICAL EXPENSE REIMBURSEMENT PROGRAM

Under current tax laws, medical and dental expenses that are less than 7.5% of your adjusted gross income are not tax deductible and must be paid with "after-tax dollars." Refer to **FLEXIBLE BENEFIT FEATURES** for additional information about the effect of the medical expense reimbursement program on your taxes.

Each year you may elect to contribute a portion of your compensation to a medical expense reimbursement account, and that amount will be deducted from your pay "pre-tax". The amount that you elect to contribute will be deducted from your compensation before it is taxed. The amount in your account will be used to reimburse you for health care expenses incurred by you or your dependents that are not covered by any other health care program. Eligible expenses include:

- Medical, dental, hearing, and vision expenses;
- Prescription and over-the-counter drugs and items purchased for personal use to alleviate or treat personal injuries or sickness; and
- Deductible and coinsurance amounts that you pay for your health care treatments.

Except for over-the-counter medications, these expenses must be eligible for Federal income tax deduction under Code Section 213(d) but you may not claim them as deductions if they are reimbursed under this program.

The following expenses are not eligible:

- The cost of qualified long-term care expenses or premiums;
- The cost of other health care programs, such as premiums paid under plans maintained by your spouse's employer or individual policies maintained by you or your spouse;
- Expenses for cosmetic surgery or cosmetic items, maternity items or wigs;
- Vacation expenses or travel expenses that are not primarily for and essential to medical care, even if for rehabilitation;
- Meals or lodging (unless included as part of a hospital bill or while traveling between distant hospitals) at a location away from home or received as an outpatient;
- Vitamins or health aids used for general health purposes and not used to treat a specific injury or illness; or
- Cosmetic procedures such as teeth whitening.

A more complete list of eligible and ineligible benefits is available from the Plan Administrator or in IRS Publication 502 - Medical and Dental Expenses at www.irs.gov/publications/index.html.

The amount allocated to this account may not exceed \$10,000 per year. The amount credited to this account may only be used to reimburse you for medical expenses that you and your dependents incur for services rendered during the plan year and on or before your termination date, if you terminate during the plan year. Medical expenses incurred before you become a participant or after your termination date are not eligible for reimbursement. For purposes of this paragraph, the term "incurred" means that the medical service is rendered or the medical supply or device is delivered to the participant, spouse or dependent for use in the plan year; provided, however, that advance payments for orthodontia and reimbursement for durable medical equipment and other expenses permitted by IRS Proposed Reg. Section 1.125-5(k)(3) will be eligible for reimbursement. If your participation terminates during the plan year we will refund to you any amount that you paid for coverage that relates to a period after your cessation of participation through the end of the plan year.

The reimbursement amount available at any time during the plan year is the annual amount that you elected, less the amount of reimbursements previously received for the plan year. Any unused medical expense reimbursement benefits (contributions to your medical expense reimbursement account for the plan year in excess of your medical claims incurred during the plan year) may not be used to pay for any other benefit, may not be carried forward to a subsequent period or plan year, may not be returned to you and must be forfeited. **If you do not submit claims up to the amount that you elected for the plan year, then any remaining amount in your account will be forfeited after the conclusion of the plan year and these forfeitures will be used as described above.**

DEPENDENT CARE REIMBURSEMENT PROGRAM

You may elect to contribute a portion of your compensation to a dependent care reimbursement account and this amount will be deducted from your compensation before it is taxed. The amount in your account will be used to reimburse you for dependent care expenses that are employment related and incurred for services rendered during the plan year and before your termination date. This includes expenses for your children or other dependents under age 13, as well as your spouse or any other dependents who are physically or mentally incapable of self-care who have the same principal place of abode as you. In cases of divorce, only the parent with whom the child shares the same principal place of abode for the greater portion of the year may participate. Employment related expenses for services outside of your home are eligible only if incurred for children under age 13 or for an individual who is age 13 or older and who regularly spends at least eight (8) hours a day in your household.

The amount allocated to this account for the plan year may not exceed your earned income, your spouse's earned income or \$5,000 (\$2,500 if you are married but you and your spouse file separate returns), whichever amount is smaller. The amount available for reimbursement at any time is limited to the amount in your account. **If you do not submit claims up to the amount that you elected for the plan year, then any remaining amount in your account will be forfeited after the conclusion of the Plan year and the forfeitures will be used as described above.**

- ***"Employment-Related" Expenses***

Employment related expenses are expenses that you incur to permit you to continue working. Generally, you may not receive reimbursement under this program if you are married and your spouse does not work and have earned income. If, however, your spouse is a full-time student or unable to work, your spouse will be deemed to have earned income of \$250 for the month if there is one qualifying individual for whom you incur dependent

care expenses and \$500 for the month if there is more than one qualifying individual for whom you incur dependent care expenses. Contact the Human Resources Department for details.

Employment-related expenses include expenses for the care of a dependent inside your home and expenses incurred outside your home for babysitters, nursery schools, or day care centers. This does not include educational expenses for children in first grade or beyond or for food, clothing, and transportation expenses. Services provided by day care centers that care for six (6) or more individuals are eligible for reimbursement only if the center complies with all applicable state and local laws. Payments to your child if the child is under age 19 or to any other relative you claim as a dependent on your tax return are not eligible for reimbursement.

- ***Other Options for Dependent Care Expenses***

If you have dependent care expenses, you may also be eligible for the federal child care tax credit. The federal child care tax credit can be claimed for a percentage of your eligible expenses (from 20% to 35%) depending upon your income level. Eligible expenses are limited to \$3,000 for one child and \$6,000 for two or more children. The amount of your child care tax credit eligible expenses is reduced, dollar for dollar, by the amount of dependent care expenses that are reimbursed through this Plan. To claim the federal child care tax credit, you must file Form 2441 - Credit for Dependent Care Expenses - with your tax return.

You may have greater tax savings if you use the federal child care tax credit instead of receiving reimbursement for dependent care expenses from the Plan. Families with low income generally obtain more tax relief using the federal child care tax credit than families with higher income. A worksheet for estimating your tax savings under both options is available from the Human Resources Department or you may contact your tax advisor to determine the method that is best for you.

Whether you use the dependent care expense account in the Plan or the federal child care tax credit, you must report the child care provider's name, address and taxpayer identification number (or social security number) on your income tax form. You must also report on your income tax form the social security number of your dependents.

EMPLOYEE ASSISTANCE PROGRAM

All employees are eligible to participate in the employee assistance program. This program provides assessment, short-term problem resolution, and referral services to employees for counseling and treatment for personal or emotional problems, including those arising out of alcohol and other substance abuse. An outline of the program is contained in the materials attached or previously distributed.

ADOPTION ASSISTANCE PROGRAM

The College reimburses you for adoption expenses of up to the indexed cost of normal childbirth for each child adopted (or 1.5 times this amount for an adoption of more than one sibling at one time) but not exceeding one child (or simultaneous sibling adoption) for any participant in a plan year. Reimbursements for amounts paid or expenses incurred before 2011 are excluded from income taxes, but subject to FICA (Social Security) taxes.

In order to be eligible for reimbursement, your adoption expenses must be "**qualified**." Qualified adoption expenses are adoption fees, court costs, attorney fees, and other expenses that are directly related to and are spent for the principal purpose of the legal adoption of an "**eligible child**." An eligible child is a person who is:

- under age 18; or
- physically or mentally incapable of caring for himself/herself.

A child who is a relative or who is a step-child is not an eligible child.

Qualified adoption expenses will not include any expenses incurred in violation of state or federal law, in carrying out any surrogate parenting arrangement, or in connection with adoption of a child of your spouse.

If you have qualified adoption expenses in excess of amounts reimbursed by our program, you may be eligible for the federal adoption expense care tax credit. You should consult with a tax advisor on the amount and timing of any tax credit that may be available to you in conjunction with an adoption.

CLAIM AND APPEAL PROCEDURES

IN GENERAL

We are the "**plan administrator**" and have the responsibility and discretionary authority for interpreting the terms of the Plan. We will resolve all disputes with respect to the interpretation of the Plan in accordance with the claim and appeal procedures for the Plan.

We also have the responsibility and discretionary authority to approve or deny all claims for self-insured benefits. Each insurance carrier has the discretionary authority to interpret its insurance policies and approve claims for its insured benefits. Our decisions and the decisions of the insurance carrier will be final.

Claims may be filed by participants and beneficiaries ("**claimants**") and will be resolved as insured benefit claims or self-insured benefit claims.

INSURED BENEFIT CLAIMS

The insurance carriers, not the College, are responsible for paying claims with respect to the insured programs. Each insurance carrier is responsible for:

- determining eligibility for and the amount of any benefits payable under its contract and benefit program, and
- prescribing claims procedures to be followed and claims forms to be used by participants for its benefit program.

Each insurance carrier is a "**fiduciary**" under the Plan with full power to interpret and apply the terms of the Plan and its insurance contract as they relate to the benefits it provides under the contract.

The insurance carrier will decide insured benefit claims in accordance with its claims procedures, as required by ERISA. The insurance carrier has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance carrier denies a claim, in whole or in part, claimants will receive a written notification setting forth the reasons for the denial.

You must submit all claims for insured benefits to the insurance carrier providing the benefit and follow that insurance carrier's claim and appeal procedure with respect to the benefits it provides. The insurance carrier may require the claimant to complete, sign, and submit a written claim on the insurer's form. These forms are available from the Human Resources Department.

Claims for benefits from an insured benefit program will be resolved under the claims procedures applicable to each insured program as described in the certificates, contracts or booklets attached or previously distributed. The insurance carriers providing benefits under the Plan are listed in the **GENERAL INFORMATION** section.

SELF-INSURED BENEFIT CLAIMS

- ***Claims administered by our TPA***

Under our self-insured programs, we pay claims for expenses. We have appointed a TPA to process claims for certain benefits. In the case of benefits administered by a TPA, the TPA will act in our place in responding to initial claims. A claimant must complete, execute and submit a written claim on the form available from the TPA or Human Resources. All claims must be supported by written evidence. Each claimant must provide to us or the TPA a written release of all medical records that are pertinent to the claim. We have the right to secure independent medical advice and to require such other evidence as we deem necessary to decide the claim.

The plan booklet for the medical benefit program describes the procedures for submitting claims that are initially resolved by a TPA. The identification of the TPA and the programs administered by the TPA are listed in the section entitled **GENERAL INFORMATION**. See the plan booklet for a description of the procedures for submitting claims to a TPA.

- ***Claims we administer***

In the case of our self-insured programs that are not administered by the TPA and other issues not involving insured benefit claims, we will review claims and advise claimants of the amount of their benefits. Claimants will receive a response within 90 days after we receive a claim, unless we determine that special circumstances require an extension of time of up to 90 days to process a claim. If additional time is needed, we will notify claimants of the special circumstances requiring the additional time and the date by which we will make a decision.

If the claimant is not eligible for a benefit, we will give the claimant an explanation in writing or electronically of why the claim is not eligible, and refer to the specific plan provisions upon which our determination is based. We will also describe any additional material or information necessary for us to process the claim and an explanation of why the material or information is necessary.

SPECIAL RULES FOR REIMBURSEMENT CLAIMS

All claims for reimbursement under the dependent care reimbursement program must be submitted to us not later than 90 days following the end of the plan year in which the expenses were incurred. Claims for reimbursement under the medical expense reimbursement program must be submitted to the TPA not later than 90 days following the end of the plan year in which the expenses were incurred.

We may specify a minimum claim amount. You may submit a smaller amount if it is the last claim for the plan year. Claims must be submitted to us on approved forms, accompanied by bills or other proof of acceptable expense claim. A written statement that the amount has not been reimbursed and is not reimbursable from any other plan must be submitted. We will make payment of covered claims directly to you on a monthly or more frequent basis.

If you die during the plan year, we will pay amounts eligible for reimbursement to your surviving spouse, if any, or to your estate. Your surviving spouse or the personal representative of your estate must submit claims along with invoices or proof of payment in order to receive reimbursement.

When your employment terminates, you may submit claims for reimbursement only for those expenses incurred prior to your date of termination. You must submit claims no later than 90 days following the end of the plan year in which your employment terminates.

If you are permitted to use a debit card to pay any expenses incurred under the plan, you must agree to the terms and conditions of the cardholder program as set forth in the cardholder agreement, including any fees applicable to using the debit card, limitations on card usage, claims substantiation requirements, the plan's right to withhold and offset for ineligible claims and any other requirements of the cardholder agreement.

APPEALS FROM DENIALS OF INSURED BENEFIT CLAIMS

If an insurance company denies a claim, the claimant may appeal to the insurance company for a review of the denied claim. The insurance company will decide appeals in accordance with its appeal procedures, as required by ERISA. See the certificate of insurance or booklet attached or previously distributed for more information about how to file a claim and for details regarding the claims procedures.

APPEALS FROM DENIALS OF SELF-INSURED BENEFIT CLAIMS

If a claim is not appealed on time, claimants may lose their right to file suit in a court due to failure to exhaust their internal administrative appeal rights. Following the internal appeal process is a requirement for bringing a suit in court in most cases.

In the case of benefit programs administered by a TPA, generally, the TPA processes initial claims and we hear and decide appeals. Some TPAs have an internal appeal process. For programs administered by a TPA, see the booklet describing the specific benefit programs to determine if the TPA has an internal review process and the procedures for obtaining internal review.

Except for benefit claims under the health care program, the procedure for filing an appeal with us is:

- At their request, we will provide claimants or their authorized representatives reasonable access to and copies of all documents, records and other information, if any, relevant to their claim for benefits;
- Claimants must file a **written** notice of appeal with us within 60 days after receiving a notice of denial. Claimants must file **in writing** all the documents, comments, records and other information relating to their appeals that they wish to have considered in the appeal with their notice of appeal;
- Appeals will be reviewed taking into account all comments, documents, records, and other information that are submitted relating to the claim without regard to whether it was submitted or considered in the initial determination.
- Unless there are special circumstances requiring more time, we will advise claimants of our decision within 60 days after receipt of the notice of appeal. If an extension is necessary, we will notify claimants before the end of the initial 60-day appeal period of the special circumstances requiring the

extension and the date by which our determination will be made. The extension will be for 60 days or less.

- We will notify the claimant of our decisions in writing in a manner that can be understood by the claimant. We will describe the reasons for the decision and refer the claimant to the specific plan provisions upon which the decision is based. The notice will contain a statement that the claimant may request reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

For appeals regarding health care benefit claims, see the program booklet prepared by the TPA, which will prescribe the time periods in which the claim must be presented and the procedures for presenting and deciding appeals. The healthcare program's TPA will have the discretionary authority and responsibility to hear and decide appeals regarding medical benefits.

SPECIAL RULES FOR DISABILITY DETERMINATIONS

For insured claims, the insurance carrier will decide claims and resolve appeals in accordance with its claims procedures, as required by ERISA. Determinations regarding self-insured disability benefits will be made in the same manner as other claims except that we will respond within 45 days after receipt of the claim. This period may be extended for two (2) additional periods of up to 30 days each in the same manner as other claims are extended. The notice of these extensions will explain the standards for making disability determinations, the unresolved issues preventing a decision and the additional information needed to resolve these issues, and claimant will have 45 days in which to provide the additional information.

Claimants may appeal an adverse determination of disability status in a manner similar to appeals on other claims. However, claimants will have 180 days following receipt of notification of notice of denial of the claim to give written notice of the appeal. In matters involving health, we will consult with a health care professional with appropriate training in the medical field involved in the medical judgment and identify all medical and vocational experts that advise us in or determination. The medical professional will be different from and independent of the professional consulted at the time of the initial claim. We will respond to claims for disability benefits in the same manner as we respond for other claims except that a period of 45 days applies instead of 60 days for our response and extension, if any.

SPECIAL RULES FOR HEALTH CARE DETERMINATIONS

If a claim is for a benefit under an insured or self-insured program providing health care coverages other than medical expense reimbursement benefits, claimants will generally proceed under the claims procedure described in the booklet for that program.

SPECIAL RULES FOR MEDICAL EXPENSE REIMBURSEMENT DETERMINATIONS

If a claim for reimbursement under the medical expense reimbursement provisions of the Plan is wholly or partially denied, the claims procedure described below will apply.

Determinations will be made regarding the medical expense reimbursement account benefits in the same manner as other self-funded claims except that a response will be sent within 30 days after receipt of the claim. This period may be extended for an additional period of up to 15 days in the same manner as other claims are extended. The notice of these extensions will specifically explain the standards for making the medical expense reimbursement determinations, the unresolved issues preventing a decision and the additional information needed to resolve these issues, and the claimant will have 45 days in which to provide the additional information.

Claimants may appeal an adverse determination of their eligibility for these benefits in a manner similar to appeals on other claims. However, claimants will have 180 days following the receipt of notification of an adverse benefit determination in which to give written notice of an appeal. In matters involving health, we will consult with a health care professional with appropriate training in the medical field involved in the medical judgment and identify all medical and vocational experts that advise us in our determination. The medical professional will be different from and independent of the professional consultant at the time of the initial claim. We will respond to claims for medical expense reimbursement in the same manner as for other claims.

WHAT IF YOUR APPEAL IS DENIED?

If your appeal is denied, you may file a lawsuit to recover Plan benefits. Claimants may not file a lawsuit to recover plan benefits before the expiration of 60 days after they have filed a claim in accordance with the requirements of this Plan and have exhausted the Plan's claim and appeal procedures. Claimants may not file a lawsuit after the earlier of (a) expiration of 24 months after the internal appeals process described above has been completed and a final decision announced or (b) the expiration of 36

months after the earliest of the date the covered services were rendered, the claim was made, the claim otherwise arises, or such other date as provided in the incorporated booklets, insurance certificates or policies of insurance that apply to the benefit that is the subject of the claim.

COBRA CONTINUATION OF COVERAGE

Under COBRA, you, your spouse or your dependent children have a right to elect continuation coverage under the health care programs and medical expense reimbursement program to the extent of your participation at the time of the events described below. A "**dependent child**" for COBRA continuation purposes includes a child born to you or placed with you for adoption during the COBRA coverage period. Continuation rights are as follows:

HEALTH CARE PROGRAM CONTINUATION COVERAGE

- ***18 Months***

You, your spouse, and/or your dependent children have a right to elect continuation coverage for a period of 18 months if coverage under the Plan is lost because of a reduction in your hours of employment or your employment terminates for reasons other than gross misconduct on your part.

If you, your spouse, or dependent are determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage, the 18-month period may be extended to 29 months.

The 18-month period may also be extended for a maximum period of 36 months for your spouse or dependent children if they elect coverage at this time and one of the events described below under "***36 months***" occurs within the initial 18-month period.

If you become entitled to Medicare coverage in the 18-month period before you lose coverage due to a termination of employment or reduction in hours, your spouse and/or children who are qualified beneficiaries may

elect continuation coverage for the 36-month period beginning on the date of your Medicare entitlement.

- ***36 Months***

Your spouse and dependent children have the right to elect continuation coverage for a period of 36 months if coverage is lost for any of the following reasons:

- Death of the participant;
- Divorce or legal separation from the participant; or
- You become entitled to Medicare.

In addition, the dependent child of a participant in the Plan has the right to elect continuation coverage on his or her behalf for a period of 36 months if coverage is lost because he or she ceases to be a "dependent child" under the terms of the College's program.

The 18-, 29-, and 36-month periods are measured from the date of the first event that causes the loss of coverage.

REDUCTION OF COVERAGE PERIOD

Continuation coverage will cease on the earlier of the conclusion of the 18-, 29- or 36-month periods described above or on the day any of the following events occur:

- Failure to pay the required premium.
- You or your covered dependents become covered by another group health plan that does not contain a pre-existing conditions limit or exclusion that affects you, your spouse or your dependents or at the time the exclusion or limitation expires.
- You or your covered dependents become covered by Medicare after electing continuation coverage.

- If you or your covered dependent have extended coverage for the additional 11-month period due to disability and it is determined that the disability no longer exists.
- We no longer provide group health coverage to any of our employees.

YOUR NOTICE OBLIGATIONS

You or your covered dependent must inform us in writing of a divorce, legal separation, child losing dependent status under the terms of the Plan, or entitlement to Medicare within 60 days of the event. You or your covered dependent must also notify us if you are determined to have been disabled under the Social Security Act at any time during the first 60 days of continuation coverage. You must notify us within 60 days after the date of the determination and before the end of the 18-month coverage period. **If you or your covered dependent fail to notify us within the periods described above, continuation coverage or additional continuation coverage will not be available.**

The notice must be in writing, must include your name, the name of any dependents experiencing the qualifying event, and the type and date of the qualifying event. If the event is a divorce or legal separation, the notice must include a copy of the judgment, decree or order of divorce or legal separation. If it is a disability determination extension, the notice must include a copy of the Social Security Administration disability determination.

In order to protect your rights and your family's rights, you must notify the Human Resources Department in writing of any changes in your address and the address for any family member.

ELECTION PERIOD

You or your covered dependents have 60 days from the later of the date of the election notice or the date coverage terminates to complete the election form provided by us and return it to us. If continuation coverage is not elected, coverage will end. If coverage is elected and required premiums are paid, coverage will continue for up to the applicable continuation period.

TYPE OF COVERAGE

Continuation coverage is provided with respect to any employee benefit program of the College that pays health care expenses. The continuation coverage provided will be identical to the coverage provided under the Plan to similarly situated active employees.

MEDICAL EXPENSE REIMBURSEMENT COVERAGE

Continuation coverage under the medical expense reimbursement program may be elected *only* if the maximum amount required to be paid for continuation coverage for the remainder of the plan year is less than the maximum benefit available to you under the medical expense reimbursement program for the remainder of the year. This continuation coverage may continue *only* for the balance of the plan year in which the qualifying event occurs. The limitations of this paragraph do not apply to part-time employees who are not eligible for medical care coverage.

The cost for medical expense reimbursement coverage for the balance of the plan year will be 102% of the amount you elected prior to the beginning of the plan year. Contributions paid after termination of employment are paid on an after-tax basis.

COST OF CONTINUATION COVERAGE

You or your covered dependents will be responsible for the "**cost**" of continuation coverage. The cost will be established by us for each plan year and may be adjusted for rate changes that take place during the plan year. The cost of coverage is an amount equal to 102% of the actual premium cost. During the additional 11 months of coverage due to disability, the cost will be increased to 150% of the actual premium cost for coverage of an individual.

The cost of continuation coverage must be paid monthly. The amount due for continuation coverage from the qualifying event to the date of the election must be paid within 45 days after the coverage is elected. The cost for the succeeding months must be paid within 30 days after the first day of each month. **If you or your covered dependent fail to make the payments on a timely basis, continuation coverage will terminate [without notice].**

CONVERSION TO INDIVIDUAL COVERAGE

When continuation coverage under the Plan ends, you or your covered dependent may be eligible for an individual conversion policy. You or your covered dependent must file an application for this coverage. Contact the Human Resources Department to obtain an application and for details on the availability and limitations of this coverage.

TRADE ACT ASSISTANCE

- *Special Second Election Period*

Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee becomes eligible for the health coverage tax credit, but only if the election is made within the six (6) months immediately after the eligible employee's group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact the Human Resources Department for additional information. **You must contact the Human Resources Department promptly after qualifying for the health coverage tax credit or you will lose your special COBRA rights.**

- *Health Coverage Tax Credit*

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance. Under the new tax provisions, eligible individuals can either take a tax credit or get an advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

YOUR RIGHTS AS A PARTICIPANT

YOUR "ERISA" RIGHTS AND PROTECTIONS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). You are entitled to:

- ***Receive Information About the Plan and Your Benefits.***

You may:

- Examine, without charge, at our office and other specified locations all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.
- Obtain, upon written request to us, 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 an updated summary plan description. We will charge you a reasonable amount for the copies.
- Receive a summary of the Plan's annual financial report. We are required to furnish you with a copy of this summary annual report (SAR).
- Continue health care coverage for yourself, spouse or dependents if coverage is lost as a result of a qualifying event. You or your covered dependents generally have to pay for this coverage. Review this Summary and other documents governing COBRA continuation rights.
- Receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health

programs if you or your covered dependents have creditable coverage from another plan.

- Receive a certificate of creditable coverage, free of charge from the group health program or health insurance issuer as follows:
 - when you lose coverage under the group health care program;
 - when you become entitled to elect COBRA continuation coverage;
 - when your COBRA continuation coverage ceases;
 - if you request it before losing coverage; and
 - if you request it up to 24 months after losing coverage (contact the Agent for Service of Process in writing at the address shown in the section titled **GENERAL INFORMATION** to request a copy.)

Without evidence of creditable coverage, you or your covered dependents may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- ***Prudent Actions by Plan Fiduciaries.***

ERISA imposes duties on the people who are responsible for the operation of the Plan. These people are called “**fiduciaries**” and they have a duty to administer the Plan prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan or exercising your rights under ERISA.

- ***Enforce Your Rights.***

If an application for a benefit is denied or ignored, in whole or in part, the claimant has 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. See the section entitled **CLAIM AND APPEAL PROCEDURES** for the schedules that apply to an appeal of a claim for benefits.

Under ERISA, there are steps claimants can take to enforce their rights:

- Claimants may file a suit in federal court if they request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days (unless the reason they did not receive them is beyond our control), or they disagree with the Plan's decision (or lack thereof) concerning the qualified status of a domestic relations order.
- Claimants may file suit in a state or federal court if they followed the Plan's application and appeal procedures and their claim for benefits is denied or ignored, in whole or in part.
- Claimants may seek assistance from the U.S. Department of Labor or file suit in a federal court if the fiduciaries misuse the Plan's money or they are discriminated against for asserting their rights.

The court will decide who should pay court costs and legal fees and may impose fines on the plan administrator. If claimants are successful, the court may order the person they have sued to pay these costs and fees. If they lose, the court may order them to pay these costs and fees.

- ***Assistance with Your Questions.***

If you have any questions about the Plan, you should contact Human Resources. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents, you may contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

The West Michigan office is located in the Federal Building at 110 Michigan Street, N.W., Grand Rapids, Michigan 49503. Addresses and phone numbers of other Regional and District EBSA Offices are available through EBSA's website.

MINIMUM HEALTH CARE RIGHTS

- ***Maternity Benefits.***

The minimum length for any hospital stay in connection with childbirth for the mother or the newborn is 48 hours following a vaginal birth and 96 hours following a cesarean birth. If the mother and the attending physician agree, the mother or the newborn may be discharged sooner. Hospital stays longer than 48 or 96 hours must be authorized under the Plan's medical necessity provisions.

- ***Women's Health and Cancer Benefits.***

If you receive benefits in connection with a mastectomy and elect reconstructive surgery, you may receive the following benefits:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications resulting from the mastectomy, including lymphedemas.

You will determine appropriate treatment in consultation with your attending physician. Coverage is subject to the same annual deductibles and coinsurance provisions that apply to the other medical and surgical benefits under this Plan. See the booklet attached or previously distributed for details.

- ***Changes in the Level of Benefits.***

The level of benefits provided under our health care program may change from time-to-time. If we make changes in the level of coverage, you will be notified in supplements to this Summary Plan Description. If you are notified electronically, you may obtain a paper copy of the supplement, free of charge, from the Human Resources Department.

- ***Qualified Medical Child Support Order.***

The health care and medical expense reimbursement programs will be provided to your children when ordered by a court in a "**qualified medical child support order.**" If we receive an order from a court of competent jurisdiction involving these programs for your children, we will notify you of the receipt of the order and give you an opportunity to comment on its contents. We will then determine whether the order satisfies the requirements of a "**qualified**" medical child support order and notify you accordingly.

If we receive an order from a court that is a "**national medical support notice,**" we will treat the notice as a qualified medical child support order as required by law. We will comply with the order and enroll the individuals named in the notice as your dependents for the required coverage.

If the order or notice meets either of the above requirements, we will provide coverage as of the later of the date specified in the order or notice or as soon as practicable after the Plan Administrator determines the order or notice is "qualified." The cost of providing coverage under a qualified medical child support order will be paid by you. We will revoke your current election for coverage and enter a new election on your behalf that will provide the coverage necessary to comply with the order. We will adjust your compensation and deductions to pay your cost for the coverage in the same manner as similarly situated participants who elect family coverage at the same level you are required to provide under the order. The adjustment will be effective beginning with the next payroll period after we determine that the order is qualified.

You may obtain, free of charge, a copy of a more detailed description of our procedures for review of these orders from the Human Resources Department..

- ***Privacy Rules.***

The privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to the health care provisions of the plan but not to those provisions addressing non-health benefits, such as disability or life insurance. We will provide you with a separate Notice of Privacy Practices describing in detail the manner in which we and the Plan use and disclose protected health information, your rights to inspect, copy and correct medical records concerning you, and the procedure for filing complaints if you think your privacy rights have been violated.

- ***Military Service Leaves of Absence***

If you take an authorized leave of absence for military service and your medical care coverage terminates, you may elect to continue coverage for yourself and your dependents under provisions of federal law governing military service that are similar to COBRA permitting continuation at your expense for up to 24 months. This law is known as the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

The College will give notices of USERRA rights and participants must elect and pay for USERRA coverage in the same manner and following the same rules as under COBRA with two exceptions. COBRA rules do not apply where such rules would conflict with USERRA or where excused due to military necessity, impossibility or unreasonableness. Second, elections for coverage under USERRA may be made and enforced only by the participant, not by a spouse or dependent.

For more information about your benefit rights and about other coverage options, see the booklet entitled "Guide to Reserve Member Benefits" from the Department of Defense or the following websites:

For Army Reserve: www.army.mil/wellbeing/family

For National Guard: www.army.mil/soldier_resources

OTHER IMPORTANT INFORMATION

THE COST OF THE BENEFITS

The costs of providing benefits under the Plan are determined as follows:

- For self-insured benefits, the "costs" are the direct payments to the service providers and the payments you receive from your reimbursement accounts.
- For insured benefits, the "costs" are the premiums charged by the insurance carriers providing the benefits.

You and the College share these costs. We will notify you about your share of the cost for each benefit program before each annual enrollment period. If the insurance companies providing plan benefits increase their premiums or if you do not elect

sufficient payroll deductions to cover the cost of the benefits you elected, we may increase your deductions by the amount necessary to provide the coverage you elected.

HOW ARE BENEFITS FUNDED AND PAID?

Some benefits under the plan are self-insured and some are fully insured. Under our self-insured programs, we pay claims for expenses. Because we pay these amounts, they are not guaranteed by a contract or policy with an insurance company. If benefit claims exceed a certain dollar amount, an insurance carrier provides "stop-loss coverage." In this circumstance, the insurance carrier pays these excess amounts to us and we will, in turn, pay the claims. We have hired a "third party administrator" or "TPA" to administer claim payments. With our approval, the TPA reviews claims and pays benefits from the money we provide. There is no special fund or trust from which self-insured benefits are paid. Our TPAs are listed in the **GENERAL INFORMATION** section on the last page of this summary.

Under our insured programs, the insurance carrier administers the programs and insures the benefits. The insurance carriers review claims and determine if the claims are payable in accordance with the terms of the contract. Our insurance carriers are listed in the **GENERAL INFORMATION** section on the last page of this summary.

ARE THERE LIMITATIONS ON BENEFITS?

- ***Proof of Insurability***

You will not be required to provide proof of insurability if you enroll in the Plan at the time you first become eligible to participate in the Plan. If you enroll in any insurance program after you are first eligible, you and any covered dependents may be required to provide proof to the insurance company or us that each of you is in good health before you will become insured. This paragraph does not apply to any of the health care programs.

- ***Duplicate Coverage Prohibited***

You cannot be covered under the health care benefits of the Plan as both an employee and a dependent, or as a dependent of more than one employee. If we employ more than one family member who is eligible to participate in the Plan, one family member will be covered as the participant and the other family members will be covered as dependents. Each family member may also be covered as a single employee.

- ***Enrollment***

No benefits will be payable until after you have satisfied all enrollment requirements of the program you have elected and until after you have received acknowledgement of enrollment and the effective date of enrollment from the insurance company in the case of insured benefits and from us in the case of benefits that are not insured. As a condition of commencing, continuing, discontinuing, or modifying your enrollment or the enrollment of your spouse or any dependent, we may require you to produce copies or certified copies of birth certificates, marriage certificates, divorce decrees, college enrollment or similar documents at the time of enrollment or at any time thereafter.

- ***Right of Recovery***

If we determine that we paid benefits to you in excess of benefits that should have been paid, we will have the right to recover those payments from the person to whom or for whom the benefits were paid.

OTHER LIMITATIONS

The Plan is only an employee benefit plan. It does not constitute a contract of employment between you and us, and does not give you any right to continued employment with us. If your employment with us terminates for any reason, you will be entitled to the benefits you have earned under the Plan in accordance with these terms and conditions. The provisions of the Plan as described in this summary will apply only to persons who are employed by us on or after January 1, 2009.

The terms of this Plan are contained in a written document and may not be modified by the oral statement of any person, including an oral statement from any insurance company, the TPA, or us. The Plan does not give you any claim, right, or cause of action, either at law or at equity, against the Plan for the acts of any service provider, such as a hospital or physician.

AMENDMENT AND TERMINATION

The Plan may be amended at any time and from time to time. If the amendment significantly changes the provisions of the Plan outlined in this summary plan

description, a new summary plan description or supplement will be furnished to participants and beneficiaries.

Although we intend to continue this Plan on a permanent basis, we reserve the right to terminate the Plan or any benefit program provided under the Plan. If the Plan is terminated, all claims incurred prior to the date of termination will be paid in accordance with the regular Plan procedures.

DEFINITIONS

Annual Open Enrollment Period. The period of at least 15 days beginning not earlier than April 15 and ending not later than June 30 each year during which you may enroll yourself or your dependents for benefits or revise your elections.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Dependent.

Hospitalization and Basic Medical Program. A dependent for the hospitalization and basic medical program is an individual described as a dependent in the booklet provided for that program.

Medical Expense Reimbursement Program. A dependent for the medical expense reimbursement program is determined in the same manner as determinations are made under the hospitalization and basic medical program.

Dependent Care Reimbursement Program. A dependent for the dependent care reimbursement program is an individual who meets the requirements for a dependent under the medical expense reimbursement program.

The rules for determining dependents are complex. Contact the Human Resources Director for more information, especially concerning children who do not live with you or for children who are not your natural, adopted or stepchildren.

Dependent Care Expenses. The expenses that are considered to be employment-related expenses under Internal Revenue Code Section 21(b)(2). These include expenses that you pay for household services and care of an eligible dependent that are necessary for gainful employment of you and your spouse, if you are married.

Disability. A physical or mental condition that prevents you from performing the usual duties for us or the duties of any position or job we make available to you and for which you are qualified by reason of training, education, or experience. You will not be considered disabled for purposes of this Plan if your condition consists of current use of alcohol, narcotics, or other controlled substances, or consists of or results from intentionally self-inflicted injury or criminal conduct in which you were engaged. For insured programs the definitions contained in the insurance contract will apply.

Election Form. The forms we provide on which you elect or waive benefits and allocate employee contributions to your premium payment and reimbursement accounts.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Full-time Employee. An employee who works a minimum of 1365 hours per year.

Health Care Coverage. Coverage under the medical, dental and vision programs of the Plan.

HIPAA. The federal Health Insurance Portability and Accountability Act of 1996 which, among other things, requires a health plan to provide special enrollment rights to participants, spouses, and beneficiaries under certain circumstances.

Medical Coverage. Coverage under the health care program of the Plan including hospitalization and basic medical, physician services and prescription drug coverage. The term "medical coverage" does not include dental or vision coverage.

National Medical Support Notice. A form of qualified medical child support order that we will enforce after only limited review.

Newborn. A child 30 days old or younger.

Plan Administrator. Hope College is the plan administrator. We have the authority to control and manage the operation and administration of the Plan.

Plan Document. The written document that addresses the establishment, administration and other aspects of the Plan.

Plan Year. The 12-month period beginning each July 1 and ending each June 30 on which records of the Plan are kept.

Qualified Medical Child Support Order (QMCSO). A court order, judgment or decree issued by a court of competent jurisdiction providing for child support or health benefit coverage for a child of a participant, provided the order, judgment or decree meets all requirements established under ERISA.

Spouse. The person of the opposite sex with respect to whom you have met all of the requirements for a valid marriage contract in the state of your marriage and all of the requirements of the Federal Defense of Marriage Act (1 USC Section 7).

TPA. The third-party administrator with whom we have contracted to perform some of the administrative duties for the Plan.

We, Us, Our or College. Hope College.

You, Your or Yourself. The participant enrolled in the Plan as an employee.

GENERAL INFORMATION

Plan Administrator: Hope College

Address: 100 East 8th Street, Suite 210
Holland, MI 49423

Phone: (616) 395-7811

Name of Plan: Hope College
Employee Benefit Plan

Type of Plan: This is a welfare benefit plan

Plan Year: July 1 through June 30

Plan Number: 503

Employer ID Number: 38-1381271

Agent for Service of Process: Director of Human Resources
Hope College
100 East 8th Street, Suite 210
Holland, MI 49423

Insurance Carriers:

| | |
|--|---|
| <i>Voluntary Dental</i> | AFLAC Columbus, Georgia 31999 |
| <i>Life, AD&D and Long-Term Disability</i> | Standard Insurance Company 1100 S.W. Sixth Avenue Portland, Oregon 97204-1281 |

Retiree Medical

Blue Cross Blue Shield of
Michigan
600 E. Lafayette Blvd. X509
Detroit, MI 48226-2998
1-866-684-8216
www.bcbsm.com

Third-Party Administrator ("TPA"):

Blue Cross Blue Shield
of Michigan
86 Monroe Center, N.W.
Grand Rapids, MI 49503

Employee Assistance Plan:

Employee Assistance Center
3351 Claystone Drive, S.E.
Grand Rapids, MI 49546
1-800-227-0905

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