PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

HOPE COLLEGE
EMPLOYEE BENEFIT PLAN

(Restated July 1, 2016)

INTRODUCTION

Hope College ("Employer" and "Plan Sponsor") maintains the Employee Benefit Plan ("Plan") for its eligible employees and retirees. The Plan includes various types of health and welfare benefits. **This document is intended to serve as the Plan document for all benefits and is also intended to serve as the Summary Plan Description, along with the documents supplied by the claim administrators, insurers, benefit providers and Employer.** This document sets forth the terms of the Plan as of July 1, 2016.

The medical/prescription drug benefits are provided on a self-funded basis, which means these benefits will be paid by Plan Sponsor from its general assets rather than through a separate trust fund or an insurance company. Blue Cross Blue Shield of Michigan (the claim administrator for the medical benefit) will provide "Benefits-at-a-Glance Schedules of Benefits" and other information. Blue Cross Blue Shield of Michigan is not the insurer of the Plan and any and all references in the documents to Blue Cross Blue Shield of Michigan should be interpreted accordingly.

In addition, the medical flexible spending account portion of Employer's flexible benefit plan is covered under this Plan on a self-funded basis. This document serves as the summary plan description for the medical flexible spending account and describes the terms of the flexible benefit plan as of July 1, 2016.

Other benefits under the Plan are provided on a fully-insured basis, which means that the benefits are paid by an insurance company subject to the terms of the applicable insurance policy. These benefits include group term life and accidental death and dismemberment ("AD&D") (base and supplemental), long-term disability (base and optional) and group travel accident insurance. The Plan also includes an employee assistance program.

Finally, Employer provides other benefits which are not subject to ERISA and technically not part of this Plan (specifically, voluntary dental, short-term disability, adoption assistance benefits, health savings accounts for employees enrolled in Employer's Orange Plan (high deductible health plan) and dependent care flexible spending accounts under Employer's flexible benefit plan). These benefits are referenced in this document for informational purposes. Eligible employees will receive separate documentation describing these benefits.

The existence of the Plan does not grant you any legal right to continue employment with Employer or affect the right of Employer to discharge you.

If you have any questions about your benefits under the Plan, please contact the Human Resources Department.

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EMPLOYEE BENEFIT PLAN

The Employee Benefit Plan is an "umbrella plan." It is intended to include all of the health and welfare benefits for employees of Hope College which are subject to the federal law known as ERISA. The following group benefits are available to eligible employees under the Plan:

- Group medical/ prescription drug benefits (under the Orange Plan (high deductible health plan ("HDHP")) and Blue Plan) for you and your eligible dependents.
- Base and supplemental group term life and accidental death and dismemberment ("AD&D") insurance coverage for you and dependent life insurance for your eligible dependents.
- Base and optional group long-term disability benefit for your non-occupational disability.
- Group travel accident insurance for salaried employees.
- Employee assistance program ("EAP") for you and your eligible dependents.
- Medical flexible spending account (under Employer's flexible benefit plan).

In addition, as indicated in the "INTRODUCTION" section, Employer provides other benefits which are not subject to ERISA and are technically not part of this Plan. However, they are referred to in this document for informational purposes. The non-ERISA benefits include voluntary dental, voluntary vision, short-term disability, adoption assistance benefits, health savings accounts ("HSAs") for employees enrolled in Employer's Orange Plan (HDHP) and dependent care flexible spending accounts under Employer's flexible benefit plan.

Employees have already received or will receive documentation describing each one of the above Plan benefits in which they enrolled. This Summary Plan Description is intended to supplement those materials. This document does not replace the provisions of the plan documents, summary plan descriptions, other benefit descriptions, insurance applications, master plans and/or group insurance contracts for a benefit, including any applicable certificates and/or riders.

The other documentation for a Plan benefit will contain the following information:

- A summary of benefits.
- With respect to health benefits:
    - A description of any deductibles, coinsurance or copayment amounts.
    - A description of any limits on benefits.

- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the booklet(s) or certificate will contain a general description of the provider network and participants will be entitled to obtain a list of providers in the network.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.

- A description of the circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that the employee might otherwise reasonably expect the Plan to provide.

EMPLOYEE ELIGIBILITY AND PARTICIPATION

Each full-time employee of Employer who is regularly scheduled to work at least 1,560 hours per year, will generally be eligible to receive all of the benefits under the Plan upon the employee's date of hire. Satisfaction of the 1,560 hours per year standard will be determined under a measurement period prior to the beginning of each plan year. Full-time employees who were eligible to receive the benefits under the Plan prior to August 1, 2013 but who are not regularly scheduled to work at least 1,560 hours per year are "grandfathered" for eligibility purposes and will continue to be eligible for the benefits under the Plan. The following employees are not eligible to participate in the Plan:

- Employees who normally work six months or less per year;
- Individuals who are treated as independent contractors;
- Leased employees;
- Student employees;

- Employees who perform services for Employer pursuant to a written agreement that does not provide for participation in the Plan;

- Employees in grant-funded positions unless the terms of the grant provide for Plan coverage;

- Part-time lecturers;

- Lecturers who are not classified as professors, associate professors or assistant professors; and

- Faculty members on sabbatical leave except to the extent they continue to receive compensation from Employer while they are on leave.

- Non-full-time employees who may become eligible for Employer-provided medical/prescription drug coverage due to Health Care Reform (see below) are not eligible for other benefits under the Plan, including the Flexible Benefits Plan. As a result, the required contributions for medical/prescription drug coverage must be paid on a post-tax basis.

Visiting faculty members are generally eligible for benefits under the Plan. However, visiting faculty members are subject to a special one year waiting period for the long-term disability benefit. There may be other special employee eligibility rules for each of the fully-insured benefits. Each insurance carrier is responsible for determining eligibility for, and the amount of, any benefits payable under its respective insurance policy.

Notwithstanding the above, resident directors are eligible for health benefits under the Plan including group medical/prescription drug benefits, the EAP and the medical flexible spending account regardless of the number of hours the resident director is scheduled to work.

Despite the general rules above, if Employer is a "large employer" as defined by Health Care Reform for purposes of the employer shared responsibility rules, additional employees (including seasonal employees, variable hours employees and part-time employees) shall also be eligible to participate in the medical/prescription drug benefits under the Plan in the following two circumstances:

- For newly-hired employees who are not full-time employees as described above, if the employee completes an initial measurement period beginning on or shortly after the employee's date of hire, during which the employee is credited with an average of at least 30 hours per week, the employee shall be eligible to enroll in the medical/prescription drug benefits under the Plan for the stability period beginning immediately after the initial measurement period and any related administrative period ends.

- For ongoing employees who are not full-time employees as described above, for each plan year, there shall be a standard measurement period before the beginning of the plan year. If the employee is credited with an average of at least 30 hours

per week during the standard measurement period, the employee shall be eligible to enroll in the medical/ prescription drug benefits under the Plan for that plan year.

Employer shall notify non-full-time employees of the starting and ending dates of their initial measurement period and stability period, and of the standard measurement period for each plan year.

If an employee who is not a full-time employee qualifies for medical/prescription drug benefits for a stability period or plan year under the measurement period rules described above, the following special rules shall apply. First, the employee may only enroll in the Orange Plan (the Blue Plan shall not be available). Second, the employee's spouse shall not be eligible (but the employee's eligible dependent children may participate). Third, the employee's required contribution for medical/prescription drug benefits may be different than the required contribution which applies to full-time employees.

DEPENDENT ELIGIBILITY AND PARTICIPATION

The following dependent eligibility and participation rules apply for all Plan purposes except as otherwise noted in this document. Further, please note that there may be special dependent eligibility rules with respect to the dependent life insurance benefit.

Spouse

A participating employee's spouse is eligible for the Plan. For purposes of this provision, a spouse includes a person who is "legally married" to an employee. For purposes of this provision, the term "spouse" does not include a spouse who is legally separated (for example, an order of separate maintenance has been entered with the court) or divorced from the employee. Moving out and filing for divorce is not legal separation for this purpose.

A participating employee's spouse who has access to health coverage through his or her employer must enroll in that health coverage. For this purpose "health coverage" means a group health plan provided by the spouse's employer (regardless of the cost or employer contribution). If the spouse enrolls in this Plan, the coverage under this Plan shall be secondary to the health coverage of his or her spouse's employer (the other group health plan or individual policy). A participating employee's spouse who is eligible for health coverage through his or her employer but who declines to enroll in that other coverage will be subject to an additional premium surcharge for medical/prescription drug coverage under this Plan for every plan year for which the other health coverage is declined.

If both spouses are eligible employees and they have one or more children who they also seek to enroll in the Plan, they will be enrolled in family coverage under the name of the employee with the highest annual compensation. If both spouses are eligible employees

and have no additional dependents who they seek to enroll in the Plan, each spouse will be enrolled in single employee health coverage.

Child

A participating employee's child is eligible for the Plan. For purposes of this provision, a child is a person who meets one of the following requirements:

- The employee's natural child, legally adopted child, child placed with the employee for legal adoption or the employee's step-child; or

- A child over whom the employee has a legal guardianship and who resides with the employee and who relies on the employee for the majority of his or her financial support.

Ineligible Dependent Children

The following dependent children are not eligible to participate in the Plan:

- **Age**. A child will cease to be considered a dependent on the last day of the month during which the dependent attains age 26, except as follows:

  - A child who became totally disabled before the last day of the month during which the child attains age 26 may continue to participate beyond age 26. To be eligible for this extension, the child must be unmarried and incapable of self-sustaining employment due to a physical or mental condition causing the child to be permanently and totally disabled. Proof of the total disability must be provided at the request of the plan administrator. Other children are not eligible for the extension described in this paragraph.

- **Employee**. A dependent child who is enrolled in the Plan as an employee of Employer.

NOTE: The above descriptions of child and ineligible dependent children apply for purposes of eligibility for the medical/prescription drug benefit under the Plan. These rules are prescribed by Health Care Reform (see the "Health Care Reform" subsection for more information). The dental and vision benefits under the Plan are not subject to Health Care Reform. However, Employer is voluntarily applying these dependent eligibility rules to the dental and vision benefits as well.

INITIAL ENROLLMENT RULES

When employees initially become eligible to participate in the Plan, they may make the following benefit elections:

Medical/Prescription Drug Benefits

Employees may elect the Orange Plan (HDHP) or Blue Plan for the employee and the employee's eligible dependents upon becoming eligible to participate. Employees may also elect to waive Employer-provided medical/prescription drug benefits. If employees elect to waive Employer-provided medical/prescription drug benefits, Employer will not be responsible for any of the employee's non-work-related health expenses. If the employee enrolls in the Orange Plan (HDHP), the employee may also be eligible to make contributions to an HSA. (See the "HEALTH SAVINGS ACCOUNT ("HSA")" section for details.)

Base Benefits

Employees will automatically be enrolled in certain "base" benefits for which there is no employee-required contribution. These benefits include base group term life/AD&D, base long-term disability, group travel accident insurance, EAP, short-term disability and adoption assistance benefits.

Voluntary/Supplemental/Optional Benefits

Employees may elect to enroll in voluntary dental, voluntary vision, supplemental group term life and AD&D, dependent life and optional long-term disability benefits by completing the application process and agreeing to pay the required contributions. Required employee contributions for the voluntary dental benefit are payable on a pre-tax payroll deduction basis. Required employee contributions for these other benefits are payable on a post-tax payroll deduction basis.

Flexible Spending Accounts

Employees may also elect to contribute to the medical and/or dependent care flexible spending accounts upon initially becoming a participant. Contributions are made on a pre-tax payroll deduction basis. However, for any plan year the employee is enrolled in the Orange Plan (high deductible health plan), the employee is not eligible to participate in the medical flexible spending account. However, there is an exception to this rule with regard to a special medical flexible spending account carryover feature. (See the "FLEXIBLE BENEFIT PLAN" section for details.)

Once employees make their elections upon initial enrollment, they generally may not be changed until the first day of the next plan year (July 1) unless the employee experiences a change in status or other qualifying event (as defined in the flexible benefit plan) or the employee has a special enrollment rights circumstance as explained below. However, an employee may change the amount the employee contributes to an HSA on at least a monthly basis as of a prospective date, in accordance with the procedures established by the plan administrator. (See the "HEALTH SAVINGS ACCOUNT ("HSA")" section for details.)

ANNUAL AND SPECIAL ENROLLMENT PERIODS

Annual Enrollment

During the open enrollment period before the beginning of each plan year (July 1), employees will have the opportunity to make benefit election changes. Before the first day of each plan year, Employer will inform employees of when the open enrollment period will occur. Benefit elections will remain in effect until the end of the plan year unless the employee requests an election change due to a change in status or other qualifying event as defined in Employer's flexible benefit plan, or the employee has a special enrollment rights circumstance as explained below. However, an employee may change the amount the employee contributes to an HSA on at least a monthly basis as of a prospective date, in accordance with the procedures established by the plan administrator. (See the "HEALTH SAVINGS ACCOUNT ("HSA")" section for details.)

Special Enrollment

If an individual experiences a loss of coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in medical/prescription drug coverage under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. But a loss of other coverage for this purpose does not include a termination for:
    - Nonpayment of required contributions.
    - Filing of a fraudulent application or claim.
    - Voluntary termination of the other coverage.
- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.
- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium

assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

Employer may contribute to the cost of each benefit. In addition, employees may be required to contribute to the cost of one or more of the benefits, as periodically determined by Employer. If employees are required to contribute to the cost of coverage, Employer will notify employees of the required contribution. Benefits are funded in the following manner:

Self-Funded

Benefits may be funded on a self-funded basis (e.g., medical/prescription drug benefits and medical flexible spending accounts). Employer will pay the self-funded benefits from its general assets. The employee's required contributions will generally be paid on a pre-tax payroll deduction basis under Employer's flexible benefit plan. However, part-time employees who become eligible for medical/prescription drug coverage due to Health Care Reform must pay for the cost of coverage on a post-tax basis.

Participant contributions will be used in their entirety prior to using Employer contributions to pay for the cost of the benefit. Employer may establish a separate bank account for the payment of self-funded benefits. If a separate bank account is established, however, it will be for bookkeeping purposes only.

Fully-Insured

Employer may purchase insurance either to provide certain benefits (e.g., group term life/AD&D insurance (base and supplemental), long-term disability (base and optional) and group travel accident insurance) or, in the case of a benefit funded on a self-funded basis, to protect Employer from large individual and aggregate losses. (See the "INITIAL ENROLLMENT RULES" section regarding whether employees are required to contribute to the cost of these benefits and whether contributions are payable on a pre-tax or post-tax payroll deduction basis."

TERMINATION OF COVERAGE

To remain eligible for benefits under the Plan, the employee must generally continue to actively work for Employer. All benefits of an employee who quits or is terminated, or otherwise leaves active full-time employment (e.g., due to layoff), and the coverage of the employee's eligible

dependents who participate in the Plan terminates on the day the employee's active employment ends.

Benefits under the Plan will also terminate on:

- The date an individual ceases to be eligible for coverage.
- The first day any required participant contributions are not timely paid.
- The effective date of the individual's voluntary withdrawal from the Plan due to a change in status or during an open enrollment period.
- The date the Plan is discontinued as a whole or a particular benefit is discontinued.
- The date on which the participant's coverage is terminated for cause by the plan administrator. (Termination for cause means the participant is found to have misrepresented information in the application for participation or on a claim for benefits.)

Employees who retire may be eligible for retiree health benefits. See the Hope College Retiree Health Benefit Plan for details.

EXTENSIONS OF COVERAGE

Some or all Plan benefits may be continued where required by law or pursuant to an Employer-provided extension.

Extensions of Health Coverage Required by Law

Employees must be allowed to continue health coverage upon the taking of an FMLA leave (see the "Family and Medical Leave Act" subsection). Further, employees and their families have the right to continue health coverage pursuant to the federal law known as COBRA. Employees may also continue health coverage in the event the employee goes on a military leave. (See the "CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA" section.)

Employer-Provided Extensions of Coverage

As described in Employer's handbooks, employees and their families may be allowed to continue health coverage and other Plan benefits upon the taking of an Employer-approved disability leave of absence or non-FMLA leave of absence.

In the event of an Employer-approved disability leave of absence, all coverages under the Plan continue while the employee is on Employer-provided short-term disability (generally six months). Any continuation of benefits to which the employee is entitled to under FMLA shall run concurrently with this Employer-provided extension. Thereafter, health benefits shall continue for an additional year upon paying the same premium as

actively-working employees. At the end of the one year period, coverage shall terminate and COBRA shall be available.

In the event of an Employer-approved non-FMLA leave of absence, health, life and disability coverages shall continue for up to one year. Faculty may continue coverage at no cost. Non-faculty may continue coverage upon paying the same premium as actively-working employees.

Further, as described in Employer's handbooks, health benefits may be extended for the spouse and dependent children for one year in the event of an employee's death. Thereafter, the spouse and dependent children may elect to continue coverage for up to 36 months pursuant to COBRA. See Employer for details concerning the duration of coverage and the required contributions.

CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA

The federal law known as COBRA allows eligible individuals to temporarily extend health coverage under the Plan in certain circumstances where coverage would otherwise end. The federal law known as USERRA gives employees who cease to be eligible for health coverage due to service in the U.S. military additional rights regarding continuation of health coverage. This section provides information regarding extensions of coverage under those laws.

COBRA Continuation Coverage

COBRA continuation coverage allows the employee and/or his or her dependents (including a child for whom the employee is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. The employee may also have continuation coverage rights with respect to his or her medical flexible spending account under Employer's flexible benefit plan.

Eligibility

The employee and/or his or her dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if Employer pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours[1] or termination of employment[2]	Employee and Dependents	18
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation[3]	Dependents	36

Extension of Continuation Coverage

If the employee and/or his or her dependents become entitled to continuation coverage as a result of the employee's termination of employment or reduction in hours, the 18-month continuation period may be extended for the employee and/or his or her dependents in the three circumstances described below ("extension events").

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, the employee's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the employee's dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the employee's termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided to the plan administrator within 60 days of the date of the second qualifying event.***

[1] A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause an employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

[2] Continuation coverage is not available if employment is terminated for gross misconduct.

[3] Elimination of the employee's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example), is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

Employee's Entitlement to Medicare

If the employee becomes entitled to Medicare benefits during the initial 18-month period, his or her dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, the employee's entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which the employee became entitled to Medicare.***

A special rule applies if the employee became entitled to Medicare before his or her termination of employment or reduction in hours. In that situation, the maximum continuation period for the employee's dependents may be extended, and may end on the later of: 36 months after the date of the employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the employee's termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that the employee or one of his or her dependents is entitled to Social Security disability benefits either before the employee's termination of employment or reduction in hours or within 60 days after the employee's termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are his or her family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of the employee's termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.***

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide the employee and his or her spouse (if any) with certain information regarding their rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of his or her eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by

the plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, the employee and/or his or her dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. The employee and/or his or her dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

The employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, the employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The form may be obtained by contacting the plan administrator at the address or telephone number listed at the end of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- The name of the employee or former employee.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance.
- If the notice relates to the employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the

defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, his or her participation in the Plan will end as provided in the "Termination" subsection.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to the qualified beneficiary and his or her dependents. Qualified beneficiaries who purchase

continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

Employer no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified

beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

Other Coverage Options

There may be other coverage options for you and your family. Now that key parts of Health Care Reform have taken effect, you have the opportunity to buy coverage through the Health Insurance Marketplace (also known as the Exchange). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Questions

Employees and/or their dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description if they have questions regarding COBRA that are not answered in this Summary Plan Description. They may also visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call their toll free number at 1-866-444 3272.

Keep Plan Administrator Informed of Address Changes

To protect their rights under COBRA, it is important that the employee and his or her dependents keep the plan administrator informed of any changes in address.

They should also keep a copy, for their records, of any notices they send to the plan administrator.

Continuation of Health Coverage Upon Military Leave

If an employee ceases to be eligible for health coverage under the Plan due to service in the U.S. military, the employee and his or her eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The employee and his or her dependents may also be entitled to elect to continue health coverage under COBRA if the employee ceases to be eligible for health coverage due to his or her military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

An employee may elect to continue health coverage under the Plan for himself or herself and his or her eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day the employee is absent from work to perform military service; or

- The period beginning on the first day the employee is absent from work to perform military service and ending with the date the employee fails to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If an employee gives Employer advance notice of a period of military service that will be 30 days or less, the plan administrator will treat the employee's notice as an election to continue health coverage during his or her military service unless the employee specifically informs Employer, in writing, that he or she wants to cancel health coverage during his or her military leave. The employee will have to pay the required premiums for his or her health coverage, but the employee will not have to complete any additional forms or paperwork to continue health coverage during his or her military service.

If an employee gives Employer advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide the employee with a notice of his or her right to elect to continue health coverage pursuant to USERRA and a form for the employee to elect USERRA continuation coverage for himself or herself and his or her eligible dependents. Unlike COBRA, the employee's dependents do not have a separate right to elect USERRA coverage. If the employee wants USERRA continuation coverage for any member of his or her family, the employee must elect it for himself or herself and all eligible dependents who are covered under the Plan when the employee's military service begins.

If an employee chooses USERRA continuation coverage, he or she must return the USERRA election form to the plan administrator within 60 days of the date it was provided to the employee. If the employee does not timely return the election form, USERRA continuation coverage will not be available to the employee and his or her eligible dependents.

A special rule applies if the employee does not give Employer advance notice of his or her military service. In that case, the employee and his or her eligible dependents will not be provided with USERRA continuation coverage during any portion of the employee's military service, but the employee can elect to reinstate health coverage (and the coverage of his or her eligible dependents) retroactive to the first day the employee was absent from work for military service under the following circumstances:

- The employee is excused from providing advance notice of his or her military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the employee to provide advance notice or the advance notice was precluded by military necessity);

- The employee affirmatively elects to reinstate the coverage; and

- The employee pays all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

For the first 30 days of military service, the employee's required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If the employee's period of military service is more than 30 days, beginning on the 31st day of his or her military service the employee's required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if the employee does not timely pay any required premiums for health coverage. If the employee's USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated. The initial premium must be paid within 45 days after the date the employee elects USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the employee initially elects USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30

days late will result in automatic termination of the employee's USERRA continuation coverage.

If the employee complies with USERRA upon returning to active employment after military service, the employee may re-enroll himself or herself and his or her eligible dependents in health coverage immediately upon returning to active employment, even if the employee and his or her eligible dependents did not elect USERRA continuation coverage during the employee's military service. Reinstatement will occur without any waiting periods.

CONVERSION PRIVILEGES

When the employee or one of his or her dependents is no longer eligible under the Plan (either as an active participant or pursuant to an extension of coverage), the employee and/or the employee's dependents may be eligible to obtain an individual conversion policy for one or more of the fully-insured benefits. The availability of this conversion and the rules concerning eligibility are set forth in the policy with each insurance carrier. See Employer for details.

SPECIAL RULES REGARDING THE HEALTH BENEFITS

There are several special rules which apply to the health benefits under the Plan but do not apply to the welfare benefits (such as group term life/AD&D and disability). This section summarizes these special rules.

Qualified Medical Child Support Orders ("QMCSO")

Despite any contrary provision in any group health benefit under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a QMCSO. Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

Auto Accident Exclusion

Medical/prescription drug benefits are not payable under the Plan for injuries received in an accident involving a motor vehicle. For this purpose, "motor vehicle" means a car or other vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power that has more than two wheels. Motor vehicle does not include a motorcycle, a moped or any off road vehicle or all-terrain vehicle. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family adequate medical benefits in the event of an accident. If you fail to maintain your motor vehicle insurance, you will not have any medical expense coverage for auto-related injuries. This exclusion applies to all participants, even those residing outside Michigan.

Health Care Reform

The medical/prescription drug benefits under the Plan have been amended and will continue to be amended to comply with the insurance market reforms of the Patient Protection and Affordable Care Act ("PPACA") and the Health Care and Education Reconciliation Act ("HCERA"). Collectively, the PPACA and the HCERA are known as Health Care Reform. The required changes included the following:

- Dependent children must be eligible to participate in the medical/prescription drug benefits under the Plan until at least the child's 26th birthday. However, Employer has extended participation through the end of the month in which the child attains age 26.

  NOTE: Because the dental and vision benefits are provided pursuant to separate insurance policies from the medical/prescription drug benefits, the dental and vision benefits are "excepted benefits" which are not subject to Health Care Reform, including the definition of dependent child. Even though the dental and vision benefits were not amended to comply with the insurance market reforms of Health Care Reform, Employer has voluntarily amended the definition of dependent child for dental and vision benefit purposes to include older children through the end of the month in which the child attains age 26.

- Any lifetime limits on the dollar value of essential health benefits under the Plan no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan were eligible to enroll in the Plan.

- Any annual limits on the dollar value of essential health benefits under the Plan no longer apply.

- Coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice is required before coverage may be retroactively terminated.

- Any pre-existing condition limitations or exclusions no longer apply.

- The Plan is not a grandfathered plan under Health Care Reform. Accordingly, the following additional insurance market reforms under Health Care Reform apply:

  - The Plan must provide certain preventive care items and services without required participant cost-sharing. However, pursuant to federal regulations, Employer has filed for an accommodation to not offer certain abortifacients and emergency contraceptives (e.g., Plan B, Mileprex and NextChoice) due to religious objections. Participants may obtain these emergency contraceptives directly

from the claim administrator for the medical/prescription drug benefits (Blue Cross Blue Shield of Michigan). Participants will receive an additional notification from Blue Cross Blue Shield of Michigan with details.

- The Plan must provide certain patient protections such as:
  - Where a participant is required to have a primary care physician (PCP), the participant may designate any participating PCP, including a pediatrician, as the PCP.
  - The Plan may not require preauthorization or referral when a participant seeks coverage for obstetric or gynecological care from a participating OB-GYN.
  - The Plan may not require preauthorization for emergency services.
  - The Plan may not impose a copayment amount or coinsurance rate for emergency services in an out-of-network emergency department of a Hospital that exceeds the requirements for in-network emergency services.
  - Maximum out-of-pocket limits are restricted.
  - Certain routine patient costs associated with clinical trials are covered.
- Participants must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo a new external review procedure.

For more information concerning Health Care Reform or any of these required changes, please contact the plan administrator.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or the newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Health Insurance Portability and Accountability Act

Under the Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, certain privacy and security rules apply to the Plan. Specifically, group health plans and health insurance issuers must make sure that medical information identifying a participant is kept private, must maintain and follow privacy policies and procedures and must notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements. (See the "HIPAA PRIVACY AND SECURITY RULES" section for further details.)

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 ("FMLA") applies to the Plan during any calendar year when Employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year. Further, the FMLA provisions apply only to eligible employees (i.e., participating employees who have been employed by Employer for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave).

A participant on an FMLA leave may continue health coverage during the leave on the same basis and at the same participant contribution rate as if the employee had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by Employer). However, if an employee takes a leave under the FMLA to care for a qualifying military service member injured in the line of active duty, the maximum period of FMLA is 26 weeks per 12-month period. If health coverage ends at the end of an FMLA leave, COBRA continuation coverage is available.

Although not required by law, Employer also voluntarily continues other coverages during a participant's FMLA leave such as life and disability benefits.

PRESCRIPTION DRUG BENEFIT

The self-funded prescription drug benefit is administered through CVS Caremark and includes a retail pharmacy benefit and a mail service benefit. Employees and their family members enrolling in medical coverage (i.e., the Orange Plan or the Blue Plan) will be automatically enrolled in prescription drug coverage as described below.

Orange Plan – Schedule of Benefits

	CVS/caremark Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	**CVS/caremark Mail Service Pharmacy** For long-term medications (Up to a 90-day supply)
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$10** for a generic prescription (after deductible)	**1-30 $10/31-83 $20/84-90 $20** for a generic prescription (after deductible)
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or healthcare provider to prescribe from your plan's preferred drug list.	**$40** for a preferred brand-name prescription (after deductible)	**1-30 $40/31-83 $80/84-90 $80** for a preferred brand-name prescription (after deductible)
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**$80** for a non-preferred brand-name prescription (after deductible)	**1-30 $80/31-83 $160/84-90 $160** for a non-preferred brand-name prescription (after deductible)
Refill Limit	None	
Annual Deductible	$1,500 per individual/$3,000 per family (combined with medical)	
Maximum Out-of-Pocket	$4,000 per individual/$6,550 per family (combined with medical)	
Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber "dispense as written," you will pay the difference between the brand-name medication and generic plus the brand copayment.		

Blue Plan – Schedule of Benefits

	CVS/caremark Retail Pharmacy Network For short-term medications (Up to a 30-day supply)	**CVS/caremark Mail Service Pharmacy** For long-term medications (Up to a 90-day supply)
Generic Medications Ask your doctor or other prescriber if there is a generic available, as these generally cost less.	**$10** for a generic prescription	**1-30 $10/31-83 $20/84-90 $20** for a generic prescription
Preferred Brand-Name Medications If a generic is not available or appropriate, ask your doctor or	**$40** for a preferred brand-name prescription	**1-30 $40/31-83 $80/84-90 $80** for a preferred brand-name prescription

healthcare provider to prescribe from your plan's preferred drug list.		
Non-Preferred Brand-Name Medications You will pay the most for medications not on your plan's preferred drug list.	**$80** for a non-preferred brand-name prescription	**1-30 $80/31-83 $160/84-90 $160** for a non-preferred brand-name prescription
Refill Limit	None	
Maximum Out-of-Pocket	$2,500 per individual/$5,000 per family (combined with medical)	
Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber "dispense as written," you will pay the difference between the brand-name medication and generic plus the brand copayment.		

Retail Pharmacy Benefit

For short-term medications (up to a 30-day supply) the prescription may be filled at a CVS pharmacy or another pharmacy in the retail network. You can find a participating pharmacy at www.caremark.com.

Mail Service Benefit

For drugs taken regularly for chronic conditions such as high blood pressure, asthma, diabetes or high cholesterol or other long-term medications (up to a 90-day supply) you will generally save money by using the mail service benefit. For more information visit www.caremark.com/faststart or call 1-800-875-0867.

Eligible Expenses

To be eligible for payment, the prescription drug must meet the definition of a prescription drug. This means a drug which is ordered by a physician and which is dispensed by an individual or by an organization licensed to dispense drugs on the order of a physician. For this purpose, prescription drug includes a drug which under federal law is required to bear the legend "Caution: federal law prohibits dispensing without a prescription," a drug which under applicable state law may only be dispensed upon the prescription of a physician, or a compound medication which contains at least one ingredient which is the prescription legend drug.

Certain **preventive care drugs** are covered at 100% and are not subject to a prescription copayment amount. These preventive care drugs may include contraceptive medications (except abortifacients and emergency contraceptives) and devices, aspirin, fluoride supplements, folic acid and tobacco cessation drugs as defined by the USPSTF, ACIP, HRSA or other sources in compliance with the provisions of Health Care Reform. In order for these preventive care drugs to be covered at 100%, the drugs must be prescription drugs but in certain circumstances over-the-counter versions of these drugs may be covered when specifically prescribed by a physician. For the current list of preventive care drugs covered at 100% visit www.caremark.com.

Eligible prescription drugs specifically include:

- Medically necessary drugs and medicines requiring a physician's prescription under federal law (legend drugs).
- ADHD and Narcolepsy drugs.
- Anabolic steroids and Androgenic steroids.
- Anorexients.
- Smoking cessation aids requiring a prescription.
- Topical acne medications (Retin-A, Differin, Avita, Ziana and Atralin).
- Acne medication (Tazorac and Fabior).
- Compounded medication of which at least one ingredient is a legend drug.
- Oral contraceptives, contraceptive devices, injectable contraceptives, contraceptive implants, contraceptives transdermal and contraceptive vaginal rings (except abortifacients and emergency contraceptives).
- Diabetic medicines and supplies including:
    - Amylin Analogs (Symlib)
    - Incretin Mimetics (Byetta, Victoza)
    - Insulin
    - Insulin needles and syringes ($0 participant cost share with insulin prescription)
    - Insulin injection devices (i.e., pens)
    - Lancets
    - Lancet Devices
    - Alcohol swabs
    - Blood and urine testing strips: Glucose
    - Acetone testing strips
    - Ketone testing strips
    - Glucagon emergency injection kit

    - Glucose (oral)
    - Blood Glucose Monitors
- Allergy serums including:
    - Emergency Allergic Reaction Kits (Bee sting kits, epi-pen, Twinject, Epinephrine Inj, Adrenaclick)
    - Allergy immune therapy – injectable and non-injectable
- Fluoride (topical fluoride dental products requiring a prescription)
- Hypoactive Sexual Desire Disorder (HSDD) Agents
- Injectables and IV Injectables
- Migraine Medicines
- Prenatal vitamins, pediatric vitamins and multiple vitamins (that require a prescription)
- Syringes other than insulin
- OTC Proton Pump Inhibitor (if prescription)
- OTC Non-sedating antihistamine (if prescription)

Prior Authorization and Step Therapy

If a participant is prescribed a certain medicine, it may require preauthorization. The purpose of the prior authorization is to ensure that participants are receiving a cost-effective drug that is well suited to treat the participant's health condition. The prescription drug claims administrator maintains a list of prescription drugs requiring prior authorization. For details, contact www.caremark.com.

Similarly, participants who take certain medications regularly to treat ongoing medical conditions may be subject to a step therapy program. In step therapy, the covered drugs a participant takes are organized in a series of steps for the participant's physician to follow in writing the prescriptions. For example, the program usually starts with generic drugs as the first step. The first step allows the participant to begin or continue treatment with a safe and effective prescription drug that is also the most affordable. If needed, more expensive brand name drugs are usually covered in the second step.

Exclusions

The prescription drug benefit shall not pay for the following drugs, drug-related items, services and supplies:

- DESI drugs
- Therapeutic devices or appliances, unless specified otherwise
- Any OTC medicine, unless specified otherwise
- Blood products, blood serum
- Experimental medicines that do not have NDC numbers
- Bulk ingredients, unless specified otherwise
- Abortifacient drugs (i.e., Mileprex)
- Contraceptives Emergency (i.e., Plan B and Next Choice)
- Insulin pumps and insulin pump supplies (covered under Medical Benefit)
- Impotency drugs – (injectable, oral, suppository kits)
- Medical foods that require a prescription (e.g., Metanx, Limbrel, Deplin)
- Respiratory therapy supplies including spacers, peak flow meters and nebulizers (may be covered under Medical Benefit)
- Vaccines/toxoids (may be covered under Medical Benefit)
- Cosmetic Drugs (including hair loss drugs, anti-wrinkle creams, hair removal creams and others requiring a prescription) (includes Botox Cosmetic and Dysport)
- Topical analgesics, convenience multi-product kits, scar products, Otic analgesics and combinations

EMPLOYEE ASSISTANCE PROGRAM

All employees who are eligible for medical/prescription drug benefits under the Plan are automatically eligible for and enrolled in the employee assistance program ("EAP"). The EAP is designed to assist employees and their family members in addressing and resolving personal problems affecting quality of life and/or job performance. The purpose of the EAP is to provide problem identification, assessment, and limited counseling services. The EAP is considered part of this Plan. The EAP provides employees with referral services and a limited number of outpatient counseling sessions. Employees will receive a further description of the benefits provided by the EAP provider (the Employee Assistance Center).

There are no claims forms to be completed with respect to the EAP. A claimant who believes that a benefit under the EAP is being denied, in whole or in part, can submit an appeal to the plan

administrator. The appeal must be submitted in writing within 180 days following any adverse benefit determination. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial review. In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to the claim for benefits.

The appeal procedure will provide for a review that does not defer to the initial benefit determination. The appeal will be conducted by an appropriate name fiduciary of the Plan who is neither the individual who made the initial determination nor a subordinate of that individual.

The plan administrator will notify the claimant of the Plan's determination on review within 60 days after the Plan's receipt of the request for a review of a benefit determination. If adverse, the notice will set forth the specific reason or reasons for the determination, refer to the specific Plan provisions on which the determination is based and describe any additional material information for the claimant to perfect the claim. The notice will also include a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA. If the determination was based upon an internal rule, guideline, protocol or similar criteria, a copy will be provided to the claimant free of charge upon request. No legal action may be brought to recover benefits under the Plan until the claimant has exhausted this appeal procedure. Further, no legal action may be brought after the expiration of one year after the claimant has been provided with a written notice denying the Plan's appeal concerning an EAP claim.

HEALTH SAVINGS ACCOUNT ("HSA")

An employee who enrolls in Employer's Orange Plan (high deductible health plan ("HDHP")) may be eligible to make contributions to an HSA. This section describes the rules concerning HSAs.

What is an HSA?

An HSA is a tax-favored IRA-type account established for an eligible individual. Contributions to an HSA are fully vested when made, and investment earnings are not taxable when earned. Distributions from the HSA are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years.

Who is Eligible to Participate in an HSA?

Employees are eligible to establish and make contributions to an HSA upon satisfying two requirements:

- The employee participates in Employer's HDHP (as that term is defined in the Internal Revenue Code) (Orange Plan) with an annual minimum deductible determined by law; and

- The employee does **not** participate in any health plan that is **not** an HDHP. The employee will **fail** to satisfy this requirement if:

    - The employee participates in a "traditional" health plan (for example, through Employer or a spouse's employer); or

    - The employee participates in a medical flexible spending account (for example, through Employer or a spouse's employer) that permits reimbursement of all types of medical claims. If a spouse has a medical flexible spending account through his or her employer, the spouse should check with that employer regarding how the medical flexible spending account coordinates with the HDHP coverage.

      To prevent participation in a medical spending account from making an employee ineligible to contribute to the HSA, the employee will not be eligible to participate in the medical spending account through Employer if the employee is enrolled in Employer's HDHP (Orange Plan). There is an exception to this rule if you elect to participate in Employer's HDHP (Orange Plan) during the immediately subsequent plan year and you also have a carryover amount (up to $500) in your medical spending account for the subsequent plan year. (See the "FLEXIBLE BENEFIT PLAN" section for details.)

Who Administers the Employee's HSA?

An HSA must be held by a trustee or custodian (such as a bank). Employer has selected PNC Bank as the trustee/custodian for the HSA. However, this arrangement will not prohibit the employee from subsequently transferring his or her HSA to another qualified trustee or custodian. If the employee elects to contribute to an HSA, Employer will forward the contributions to the trustee or custodian. (If you elect to make pre-tax contributions to the HSA, you must select PNC Bank as the trustee/custodian of your HSA. If you want to use a different trustee or custodian you can make HSA contributions to that HSA on a post-tax, fully-deductible, non-payroll deduction basis.) The money in the HSA will be invested by the trustee or custodian. The trustee or custodian will provide the employee with more information regarding how the HSA balance will be invested and any election opportunities the employee has with respect to the investments.

What are the Rules for Making HSA Contributions?

IRS rules govern who is eligible to make HSA contributions and the amount that can be contributed each calendar year.

Employees may begin to contribute to an HSA on the first day of the month on or after the date the employee becomes enrolled in Employer's HDHP (Orange Plan) and is eligible to make HSA contributions.

Employees can make tax-deductible contributions directly to an HSA, or employees can elect to make pre-tax contributions to an HSA through Employer's flexible benefit plan, if applicable.

What are the Election Procedures for Making Pre-Tax HSA Contributions?

Employees must complete an election form in order to make pre-tax contributions to the HSA through Employer's flexible benefit plan. If the employee elects to make pre-tax contributions to an HSA through Employer's flexible benefit plan, Employer will directly deposit the contributions with the trustee or custodian of the HSA.

If the employee does not deliver a completed election form to Employer before the required date (i.e., initial date of participation in Employer's HDHP (Orange Plan)), no pre-tax pay reductions will be initially made to the HSA. However, pre-tax pay reductions to the HSA may be made starting as of a subsequent date in accordance with the procedures established by Employer.

Employees can elect to increase, decrease, stop or begin pre-tax HSA contributions at least monthly, as of any prospective date, in accordance with procedures established by Employer.

The ability to make pre-tax contributions to the HSA ends on the date that the employee ceases to meet the eligibility requirements under Employer's flexible benefit plan.

Will Employer Make Contributions to Employees' HSAs?

Employer does not currently contribute to employees' HSAs.

Is There a Limit on HSA Contributions?

The IRS limits the HSA contributions the employee may make each calendar year. The maximum amount depends on whether the employee is enrolled in single/employee-only or family coverage. There is a maximum annual contribution to the HSA if the employee is enrolled in single/employee-only coverage under the HDHP (Orange Plan) and a maximum annual contribution if the employee is enrolled in family coverage under the HDHP (Orange Plan). The maximum may be adjusted each year for changes in the cost-of-living.

If the employee will be at least age 55 by December 31, the maximum annual HSA contribution limit for that calendar year will be increased under a special catch-up rule. This amount may also be adjusted in future years for changes in the cost-of-living.

The IRS announces the maximum HSA annual contribution and catch-up contribution amounts in IRS Publication 969.

When Do Employees Lose Eligibility to Make HSA Contributions?

If the employee terminates employment, loses or drops coverage under Employer's HDHP (Orange Plan), or otherwise becomes ineligible to make HSA contributions (for example, by becoming covered by a medical flexible spending account that reimburses all types of medical claims), the employee will no longer be eligible to contribute to the HSA as of the last day of the month during which the employee terminates employment or otherwise becomes ineligible.

However, if the employee continues to participate in Employer's HDHP (Orange Plan) (for example, by electing COBRA), the employee may still be eligible to make tax-deductible contributions directly to the HSA.

How Can the Employee Access His or Her HSA Funds?

Once an HSA is established, it may be accessed by following the procedures established by the trustee or custodian. Typically, this will require the submission of a written reimbursement request form to the trustee or custodian.

Amounts in the employee's HSA can be distributed to cover the deductible requirements under the HDHP (Orange Plan). The employee can also use HSA money to pay for eligible health care expenses not covered by the HDHP (Orange Plan). Amounts distributed for health care expenses are tax-free. The employee can also request a distribution for other purposes. For expenses other than eligible health care expenses, the amount distributed is taxable income and is also subject to a 20% penalty tax. But in certain circumstances the 20% penalty tax may be waived (such as for individuals who are disabled or at least age 65).

What if the Employee Changes Jobs?

HSAs are permanent and portable. Employees can take their HSA with them to their next job. The dollars in the HSA account can continue to grow through investment or the employee can use the monies for eligible health care expenses. However, in order to actively continue to contribute to an HSA, the employee must be covered under a qualified HDHP either through his or her new employer or through an individual policy.

What Happens to the HSA after the Employee Turns Age 65?

After the employee reaches age 65, the HSA can be used to pay eligible health care expenses and certain insurance premiums like Medicare Parts A and B. Monies cannot be used to purchase a Medigap policy. Distributions for eligible health care expenses are tax-free. Distributions for other expenses are taxable.

For more information regarding HSAs, please see Employer's "Frequently Asked Questions" document (which can be obtained from the Human Resources Department).

THE FLEXIBLE BENEFIT PLAN

The flexible benefit plan allows you to design a benefits package to suit the individual needs of you and your family. If you are an eligible employee, you have the following benefit choices under the flexible benefit plan:

- You may elect to pay your required portion of the premium for medical/prescription drug and/or voluntary dental and/or voluntary vision benefits available under the Plan on a before-tax basis. However, if you are a part-time employee who becomes eligible for medical/prescription drug coverage due to Health Care Reform, you must pay for the cost of coverage on a post-tax basis.

- You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying medical expenses under the medical flexible spending account. However, for any plan year during which you are enrolled in Employer's Orange Plan (high deductible health plan ("HDHP")), you are not eligible to participate in the medical flexible spending account. There is an exception to this rule with regard to the medical flexible spending account carryover feature. (See the "Medical Flexible Spending Account" subsection for details.)

- You may elect to reduce your pay to be reimbursed on a before-tax basis for certain qualifying dependent care expenses under the dependent care flexible spending account.

- If you are only covered by Employer's Orange Plan (HDHP), you may elect to reduce your pay to make contributions on a pre-tax basis to your health savings account ("HSA"). For the purpose of making pre-tax HSA contributions, you may become a participant in the flexible benefit plan on the first day of any month on or after the date you become enrolled in Employer's Orange Plan (HDHP) and are eligible to make HSA contributions.

More information regarding the types of tax-free benefits which you may choose and the procedures for making your benefit elections are explained in the following sections.

Termination of Participation

If you terminate employment with Employer, or otherwise become ineligible to participate in the Plan, your participation in the flexible benefit plan will also end.

- You will no longer be eligible to use before-tax income to pay for Employer-provided health coverage.

- You will no longer be eligible to set aside additional before-tax income to pay for the reimbursement of certain medical expenses or dependent care expenses under the flexible spending accounts.

- If you have an amount remaining in your medical flexible spending account when you stop participating in the Plan, you may continue to turn in claims for reimbursement of expenses incurred through the date you terminated participation. You are generally not eligible to be reimbursed for claims incurring after you terminated participation. If you have an amount remaining in your medical flexible spending account when you stop participating, you may be eligible to continue participation pursuant to COBRA. Under COBRA, if the amount contributed to your medical flexible spending account for the plan year exceeds the claims you have submitted for the plan year, you will generally be eligible to continue to participate for the remaining portion of the plan year during which your participation terminated.

  If you are eligible to continue COBRA with respect to your medical flexible spending account, you may continue participation by making after-tax contributions on a monthly basis in an amount equal to 102% of the pay reductions which were allocated to your medical flexible spending account each month before terminated participation. After-tax contributions for a month must be paid by the first day of that month. However, there is a 30-day grace period for timely payment. Participation will be terminated if contributions are not made on a timely basis.

- If you have an amount remaining in your dependent care flexible spending account when you stop participating in the Plan, the amount in your account may continue to be applied toward the reimbursement of claims for eligible expenses incurred through the date your participation terminated.

- You will no longer be eligible to contribute to your HSA by reducing your pay (but you may still make tax deductible contributions directly to the HSA while you are a participant in Employer's Orange Plan (HDHP) (for example, pursuant to COBRA or a conversion privilege)).

- If you are rehired during the same plan year in which you terminate employment, there are special rules which may apply to you. If you become eligible to participate in the flexible benefit plan again during the same plan year, you should contact Employer for further details regarding these special eligibility rules.

Benefit Choices

For each plan year, you may choose from the following benefits:

Health Benefits (Medical/Prescription Drug, Voluntary Dental and Voluntary Vision)

You must pay a portion of the cost of Employer-provided medical/prescription drug benefits if you decide to participate. You must pay the entire premium for Employer-provided voluntary dental benefits and voluntary vision benefits if you decide to participate. You have two choices with regard to the health benefits for you and your dependents:

- You may elect to receive the health benefits and pay your share of the cost with your pre-tax pay reductions; or

- You may elect to waive the health benefits. If you waive coverage, Employer will not be responsible for any of your non-work-related health expenses.

Flexible Spending Accounts

You may make pre-tax pay reduction contributions to obtain reimbursement of qualifying medical expenses and/or dependent care expenses under the flexible spending accounts. However, for any plan year during which you are enrolled in Employer's Orange Plan (HDHP), you are not eligible to participate in the medical flexible spending account. There is an exception to this rule with regard to the medical flexible spending account carryover feature. (See the "Medical Flexible Spending Account" subsection for details.)

Health Savings Accounts

If you are **only** covered by Employer's Orange Plan (HDHP) as that term is defined in the Internal Revenue Code) and not covered by other health insurance, you may use your pay reductions to contribute to an HSA (see the "HEALTH SAVINGS ACCOUNT ("HSA") section).

Your Pay Reductions

You may select different types of tax-free benefits under the flexible benefit plan by reducing your pay to purchase the benefits. For each plan year, you may elect to reduce your pay for each pay period in an equal amount. Your W-2 Form (which you use to compute your income taxes) will be reduced by the total amount of your pay reductions so you will not pay income taxes on this portion of your pay. In addition, your pay reductions are not subject to FICA.

The advantage to you is that, unlike money you receive in your paycheck, there is no income tax or FICA withheld on the benefits you receive. Therefore, if you know you will need health coverage under Employer's group health plan, or will incur an expense which may be reimbursed through your flexible spending accounts or you are eligible to make HSA contributions, you could reduce your pay and obtain the coverage or make the contributions with "before-tax" income rather than "after-tax" income.

The only disadvantage is that the pay reductions reduce the amount of your pay that is reported to the Social Security Administration. This may cause a small reduction in the amount of your Social Security benefits.

You may elect to reduce your pay in the election process. The election procedures will be provided to you during the open enrollment period (see the "Choosing Your Benefits" section below).

Choosing Your Benefits

This section describes the procedure for choosing benefits under the flexible benefit plan. You may generally not change your election during the plan year, except as described below.

Initial Benefit Selection

Generally, you must make an election before the date that you become a participant. Employer will inform you of the election procedures. There are special election rules regarding your HSA (see the "HEALTH SAVINGS ACCOUNT ("HSA")" section for more information). If you do not timely elect benefits, you will be deemed to waive group health coverage and participation in the flexible spending accounts for the remainder of the plan year. After you make your choice, you may change your election only during an open enrollment period or if you have one of the events that permits an election change during a plan year.

Annual Benefit Selection

There will be an open enrollment period before the start of each plan year. You must make a new election during the open enrollment period for each plan year. The new election will become effective as of the first day of the next plan year and will remain in effect through the last day of the plan year. After the plan year begins, you may change your election only during the next open enrollment period or if you have one of the events that permits an election change during a plan year.

If you do not make a new election during the open enrollment period, your prior health benefit elections will be continued. You will be considered to have agreed to pay the appropriate premiums for the subsequent plan year for the coverages. However, if you do not make a new election during the annual open enrollment period, you will be deemed to have waived participation in the flexible spending accounts for the next plan year. There are special election rules regarding your HSA (see the "HEALTH SAVINGS ACCOUNT ("HSA")" section).

Changing Your Election during a Plan Year

As a general rule, you may only change your benefit election annually during an open enrollment period. However, you may change your election during a plan year in certain

situations for which federal law permits a new election. In no event may you change your benefit election for a plan year after that plan year ends. These rules do not apply to an HSA (see the "HEALTH SAVINGS ACCOUNT ("HSA")" section) The next sections describe these situations.

Change in Status

A change in status is an exception to the rule prohibiting any change during a plan year in your benefit election. A change in status is limited to situations where your status has changed during the plan year and this change affects the benefit election you made earlier.

The following events are changes in status:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment;

- An event that changes the number of your dependents, including birth, adoption, placement for adoption and death of your dependent;

- An event affecting the employment status of you or your spouse or dependent, including a termination or a commencement of employment, a commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status which affects an individual's eligibility for benefits;

- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to the attainment of a specified age or any similar circumstance; or

- A change in the place of residence of you or your spouse or dependent that affects your previous election.

If you have a change in status, you may change your election only if the change is on account of, and corresponds with, the change in status that affects eligibility for coverage. The following special rules apply:

- If you want to decrease or cancel Employer-provided health coverage because you become eligible for coverage under the plan of the employer of your spouse due to a legal marital or employment change in status, the change will only be permitted if coverage is or will be actually obtained under the other plan.

- With respect to your medical flexible spending account, you may elect to decrease your annual contribution amount, but not below the amount that has already been reimbursed to you for the plan year.

- With respect to your dependent care flexible spending account, an election change may be made if your dependent attains age 13 or ceases to be totally disabled.

If you have a change in status during a plan year, you may make a new election within 30 days after the change in status occurs. The new election will be effective at the time determined by the plan administrator. If you do not submit a new election within 30 days after the change in status, you must wait until the next open enrollment period to change your election. Further, any new election involving a third party insurer will only be approved to the extent permitted by the third party insurer.

Special Enrollment Rights

You may have special rights under HIPAA to enroll in Employer's group health coverage (see the "ANNUAL AND SPECIAL ENROLLMENT PERIODS" section).

FMLA Leaves

As discussed in the "Family and Medical Leave Act" subsection earlier in this Summary Plan Description, if you go on an FMLA leave, you may continue or revoke your election regarding group health coverage. Similarly, you may continue or revoke your medical flexible spending account election even if you do not otherwise have a change in status. If you terminate coverage in your medical flexible spending account during the FMLA leave, your account cannot be used to reimburse expenses incurred during the FMLA leave. Also, your total medical flexible spending account benefits during the plan year may be reduced on a pro rata basis for the time period in which your coverage was not in effect.

Court Order

You may change your election regarding Employer's group health coverage because of a court order resulting from a divorce, legal separation or change in legal custody that requires health coverage for one or more of your children. Specifically, you may:

- Elect coverage for the child if the court order requires you to add the child to the Employer's group health coverage in which you are enrolled; or

- Cancel coverage for the child if the court order requires the spouse, former spouse or other person to provide coverage and the other coverage is actually provided.

Medicare or Medicaid Coverage

If you or one of your dependents becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage consisting only of pediatric vaccine benefits), you may elect to cancel or reduce coverage for that individual under Employer's group health insurance. In addition, if you or one of your dependents loses Medicare or Medicaid eligibility, you may elect to begin or increase coverage for that individual under Employer's group health coverage.

Cost and Coverage Changes

If the cost of coverage under Employer's group health plan changes during the plan year, your compensation reductions may be automatically adjusted. However, if the cost increase is significant, you may either agree to the increase, change your election to another comparable benefit option, or drop coverage if no other comparable benefit option is available. Also, subject to the special enrollment rights rules of HIPAA, if the cost decrease is significant, you may elect the reduced cost option even if you did not previously elect it for the plan year.

If coverage under Employer's group health plan is significantly curtailed or ceases during the plan year, you may elect to receive coverage under another comparable benefit option. If coverage ceases, you may elect to drop coverage if there is no other comparable benefit option. Further, if Employer offers a new or significantly improved benefit or coverage option, you may prospectively elect the new or significantly improved option.

Finally, if you or your spouse or dependent has a change in coverage under another group health plan where the change is as a result of one of the circumstances described in this section or where the change is made during the annual open enrollment period of the other plan, you may make a corresponding election change.

Your Pre-Tax Premium Payments

If you elect to receive coverage under Employer's group health plan, your pay will be reduced by the amount stated in your election. Your premiums will automatically be paid when they come due. However, if your employment is temporarily interrupted and you do not receive pay, you will still be required to pay your premium amounts when they are due.

Medical Flexible Spending Account

What Amount of Pay Reductions Should I Allocate to My Medical Flexible Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your medical flexible spending account and, if so, how much to reduce your pay. In order to comply with Health Care Reform, the maximum amount you may have credited to your medical flexible spending account for the plan year is $2,550. (This amount is increasing to $2,600 for the plan year beginning July 1, 2017.)

If you know you will have qualifying medical expenses during the plan year which will not be covered by Employer's group health plan or another health plan in which you participate, you should consider putting enough in your medical flexible spending account to cover these planned-for expenses. The amount in your account will be used to pay all the qualifying medical expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the amount to put in your medical flexible spending account, it is wise not to put in too much. Federal law generally does not allow you to withdraw any unused amounts or to carry them over to the next plan year. However, at the end of the plan year (ending June 30), up to $500 of any unused amount may be carried over to the next plan year. At the end of the plan year (June 30), all unused amounts in excess of $500 must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Medical Flexible Spending Account?

Qualifying Individuals

Your qualifying medical expenses may be reimbursed under the Plan. Qualifying medical expenses may be incurred for:

- You;
- Your spouse;
- Your natural child, your adopted child, a child placed with you for adoption, or your step-child until the last day of the month during which the child attains age 26; or
- Other children, relatives and members of your household who are your "qualifying child" or "qualifying relative" under IRS guidelines.
    - A qualifying child is your child or other relative who is younger than you, who lives with you, who

does not provide more than half of his or her own financial support and who meets certain other requirements. Such an individual will be your qualifying child until the end of the calendar year in which the individual turns 18 or 23 (if a full-time student). However, this age requirement is waived for a qualifying child who is totally disabled.

- A qualifying relative is your child, other relative, or member of your household for whom you provide over half the individual's financial support and the individual is not the qualifying child of you or any other individual.

Qualifying Medical Expenses

- To be eligible for reimbursement from your medical flexible spending account, the expense must be a "qualifying medical expense." To constitute a qualifying medical expense, the expense must be deductible on your federal tax return (without regard to the adjusted gross income limitation which is generally 10%). Further, the expense must not be covered by Employer's health plan (medical, prescription drug, dental or vision) or any other source. The expense must be incurred during the plan year.

  Expenses are considered to be incurred when the services are rendered or supplies are provided, not when billed or paid. However, orthodontia services may be reimbursed before the services are provided but only to the extent that you have actually made payment in advance in order to receive the services. These orthodontia services are deemed to be incurred when you make the advance payment.

  For a complete list of expenses that are considered to be "qualifying medical expenses," see the Hope College HR benefits website.

Special Rule for HSA Participants

An HSA is a tax-favored IRA type of account established for an eligible individual who is covered only by a qualified HDHP. If a person has coverage under a non-HDHP, that person is ineligible for the HSA.

A medical spending account is usually considered to be a non-HDHP. As a result, a person who participates in an HDHP and contributes to an HSA

should generally not be covered under a medical spending account. For this reason, for any plan year in which you elect to enroll in the Employer's HDHP (Orange Plan), you will not be eligible to participate in the medical spending account portion of the flexible benefit plan regardless of whether or not you actually contribute to the HSA.

There is an exception to the above rule with regard to the carryover feature. (See the "Carryover Rule" subsection for details.) If you are eligible for an up to $500 carryover of unused amounts to the next plan year and you enroll in Employer's HDHP (Orange Plan) for that subsequent plan year, you will only be eligible to submit claims for uninsured dental and vision expenses. This is known as a "limited purpose" medical spending account. Again, this is to ensure your HSA eligibility.

Further, if you have a spouse or dependent who participates in an HSA and qualified HDHP (e.g., through his or her employer), you and your dependents should not participate in the medical spending account portion of the flexible benefit plan for the entire plan year in which you, your spouse or dependent participates in the HSA in order for your spouse or dependent to be eligible for the HSA.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of qualifying medical expenses to Employer. You will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred, the name and address of the person or entity to which the expense was paid and a statement that the expense has not been paid or reimbursed by, nor will you seek payment or reimbursement under any other employer-sponsored plan, any federal, state, or other governmental plan or program, or any other source. If you are enrolled in the combination limited purpose/post deductible medical spending account, the claim for reimbursement must also provide information from an independent third party that the expenses were for a permitted limited purpose (for example, dental, vision or preventative care) or were incurred after the deductible under Employer's high deductible health plan had been satisfied.

Your medical flexible spending account resembles an insurance policy. You are entitled to uniform coverage throughout the plan year. For example, if you incur $100 of qualifying medical expenses during the first month of the plan year, you may be reimbursed for those expenses immediately, even if you only have $50 credited to your account during that month. However, claims may not be reimbursed to the extent that they exceed the total amount of pay reductions you have allocated to your medical flexible spending account for the plan year (plus any carryover amount – see below). Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after Employer receives the claim, but no less frequently than monthly.

Claims for qualifying medical expenses incurred during a plan year generally may only be reimbursed out of your account balance for that plan year (subject to the carryover rule described below). All claims incurred during a plan year must be turned in no later than 90 days after the end of the plan year. If you do not timely submit a claim, the claim will be denied. As required by law, any amount then remaining in your account may be forfeited.

Carryover Rule

The carryover rule is an exception to the normal forfeiture rule under the Plan. Under the carryover rule, if you are a participant in the Plan at the end of the plan year and you have an unspent balance in your medical spending account at the end of the plan year, the balance, up to a maximum of $500, may be carried over and used to pay for qualifying medical expenses incurred in the following year.

Please remember that if you are enrolled Employer's high deductible health plan (the Orange Plan) for the following year, you may only use the carryover amount and not make any additional contributions to the medical spending account for the entire plan year in which you participate in the high deductible health plan. Further, qualifying medical expenses for purposes of the carryover will be confined to uninsured dental and vision expenses in order to ensure your HSA eligibility.

Dependent Care Flexible Spending Account

What is the Difference Between My Dependent Care Flexible Spending Account and the Dependent Care Tax Credit?

The Internal Revenue Code gives you two choices in the treatment of dependent care expenses for income tax purposes. First, you may pay for dependent care expenses with "pre-tax" income through the Plan. Second, you may claim a tax credit on dependent care expenses (up to $3,000 for one child and up to $6,000 for two or more children). However, any amount you claim under the dependent care tax credit will be reduced by the amount you are reimbursed under the Plan.

What Amount of Pay Reductions Should I Allocate to My Dependent Care Flexible Spending Account?

It is entirely up to you to determine whether to allocate any pay reductions to your dependent care spending account and, if so, how much to reduce your pay. If you know you will have dependent care expenses during the plan year, you should consider putting enough in your dependent care spending account to cover these planned-for expenses. The amount in your account will be used to pay all the dependent care expenses for which you are responsible. However, you will still be required to pay for any expenses which exceed the amount in your account.

In deciding on the proper amount to put in your dependent care spending account, it is wise not to put in too much. For example, if you do not have to pay for dependent care on holidays and while you are on vacation, you should take this into consideration when you determine the amount you want to have credited to your account. Federal law does not allow you to withdraw any unused amounts or to carry them over to the next plan year. At the end of the plan year (June 30), all unused amounts must be forfeited.

What Types of Expenses Are Eligible for Reimbursement From My Dependent Flexible Care Spending Account?

Your dependent care expenses may be reimbursed under the Plan. Dependent care expenses are your expenses for certain services which your dependents need in order for you to be employed by Employer.

The Internal Revenue Code defines who is considered your dependent for this purpose:

- Your dependent includes a qualifying child who is younger than you, who lives with you for more than half of the year, who does not provide over half of his or her own financial support for the year and who meets certain other requirements. A child of divorced parents who is under age 13 or totally disabled will be treated as a dependent of the custodial parent, even if the child is a dependent of the noncustodial parent for income tax purposes.

- Your dependent also includes a qualifying relative such as your parent who receives over half of his or her financial support for the year from you.

The types of services covered are:

- Care for your dependent in your home (such as babysitting), if the dependent is either:

    - Your qualifying child under age 13; or

    - Your spouse or qualifying relative who is totally disabled. A person is totally disabled if the person has a mental or physical condition which makes the person incapable of caring for his or her hygienic or nutritional needs, or causes the person to require the full-time attention of another person for his or her personal safety or the safety of others.

- Care for your dependent outside of your home (such as in a day care center), if the dependent is either:

- Under age 13; or

- Totally disabled (as defined above) and regularly spends at least eight hours per day in your home.

  This also includes pay, per an agreement with your daycare provider, which is required in order to hold a place for your child(ren) during your short, temporary absence from work (for example, during vacation or your short term illness).

- Household services for the maintenance of your home (such as for a domestic maid or cook) as long as the services are performed in part for the benefit of your dependent.

May Amounts Paid to My Relatives Be Reimbursed?

You may hire whomever you want to provide services to your dependents. However, federal law provides that dependent care expenses cannot be reimbursed under the Plan if one of the following relatives provides the care:

- One of your dependents;

- Your spouse; or

- Your child (even if not your dependent), if your child is under age 19 on December 31 of the year during which the care is provided.

Are There Limits on How Much May Be Reimbursed?

Federal law limits the amount of dependent care expenses which may be reimbursed under the Plan. Generally, the limit is $5,000 per calendar year (or $2,500 if you are married and file a separate tax return).

However, if you earn less than $10,000 or your spouse earns less than $5,000, the limit is the lesser of your spouse's pay or ½ of your pay. A further limit applies if you and your spouse are filing separate tax returns. If your spouse is a full-time student or is totally disabled (as defined above) for any month in which you have dependent care expenses, your spouse will be considered to have the following pay for that month:

- $250, if you have dependent care expenses for one dependent; or

- $500, if you have dependent care expenses for more than one dependent.

How Do I Make a Claim for Reimbursement?

You should send your claims for reimbursement of dependent care expenses to Employer. You will need to provide the information necessary to substantiate each claim. This information includes the date each expense was incurred, the amount of the expense, the name of the person for whom the expense was incurred and the name and address of the person or entity to which the dependent care expense was paid. You will also need to provide or certify that you have obtained the taxpayer identification number (in the case of an entity) or the Social Security number (in the case of a person) of the entity or person that provided the dependent care. You are required to obtain this information in order to report your dependent care expenses with your tax return on IRS Form 2441.

A claim will only be paid to the extent of the balance in your account at the time the claim is filed. If the balance in your account is insufficient to pay the claim in full, the unpaid balance of the claim will be carried over and paid when a sufficient amount is credited to your account later in the plan year. Also, only claims for qualifying expenses will be reimbursed.

Reimbursement payments are made as soon as administratively feasible after Employer receives the claim, but no less frequently than monthly.

Claims for dependent care expenses incurred during a plan year may only be reimbursed out of your account for that plan year. All claims incurred during a plan year must be turned in no later than 90 days after the end of the plan year. If you do not timely submit a claim, the claim will be denied. As required by law, any amount then remaining in your account will be forfeited.

Appeal Procedure for Medical and Dependent Care Flexible Spending Accounts

If your claim for benefits under the flexible spending accounts has only been partially reimbursed or denied, you will be given notice of the nonpayment or denial. The notice will be given within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that you are notified, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you will be granted 45 days from the receipt of the notice within which to provide the information. The Plan's period for making the benefit determination will be the 15-day period beginning on the date it receives this additional information.

If you do not provide the additional information within 45 days from the receipt of the notice of the extension, the Plan may issue a denial of the claim within 15 days after the end of the 45-day period.

Notification of any adverse benefit determination will set forth the specific reason or reasons for the adverse benefit determination, refer to the specific Plan provisions on

which the determination is based, and describe any additional material or information necessary for you to perfect the claim. The notice will also describe the Plan's review procedures and related time limits and a statement of your right to bring a civil action under Section 502(a) of ERISA (with respect to a medical flexible spending account claim) following an adverse benefit determination on review. If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a copy will be provided to you free of charge upon request.

You may request a review of any adverse benefit determination by submitting a written application to the plan administrator within 180 days following the denial of the claim. You may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted r considered in the initial benefit determination. In filing the appeal, you will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to your claim for benefits.

The appeal procedure will provide for a review that does not defer to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual.

The plan administrator will notify you of the Plan's determination on review within 60 days after the Plan's receipt of your request for a review of an adverse benefit determination. If adverse, the notice will include the same information which must be included in the notification of the initial adverse benefit determination.

The Plan will not be required to pay interest on any claim for benefits, regardless of when paid. Also, if a check for the payment of Plan benefits is not cashed within one year after the date it is issued, the check will be dishonored.

CLAIM AND APPEAL PROCEDURES

This section sets forth claim and appeal procedures for the self-funded medical and prescription drug benefits. The claim and appeal procedures for the EAP are set forth in the "EMPLOYEE ASSISTANCE PROGRAM" section. The claim and appeal procedures for the flexible spending accounts are described in the "THE FLEXIBLE BENEFIT PLAN" section. Each insurance carrier is responsible for prescribing the claims procedures to be followed with regard to the fully-insured benefits provided pursuant to that carrier's policy. The insurance certificate(s) or booklet(s) from the insurer(s) contain a summary of the claims procedures for the fully-insured benefits.

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an

extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by the Plan of that course of treatment (other than by Plan amendment or termination), will constitute an adverse benefit determination. Notice will be provided in accordance with the "Benefit Determination Notice" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Benefit Determination Notice

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA (a federal law) following an adverse benefit determination on review.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination regarding a health claim by submitting a written application to the Plan within 180 days following the denial of the claim. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon. The Plan shall not base decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

In the case of an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be two levels of appeal for pre-service claims. Both levels of appeal will be conducted by the claim administrator (and the claim administrator will be a Plan fiduciary for this purpose). The claim administrator will notify the claimant of its determination regarding a first level appeal within 15 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level of appeal to the claim administrator within 60 days after receiving written notice of the denial of the first level appeal. If the claimant submits a second appeal, the plan administrator will notify the claimant of its determination regarding a second level appeal within 15 days after receipt of the claimant's request of a second level review of an adverse benefit determination.

Post-Service Health Claims

There will be two levels of appeal for post-service claims. Both levels of appeal will be conducted by the claim administrator (and the claim administrator will be a Plan fiduciary for this purpose). The claim administrator will notify the claimant of its determination regarding a first level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level of appeal to the claim administrator within 60 days after receiving written notice of the denial of the first level appeal. If the claimant submits a second appeal, the claim administrator will notify the claimant of its determination regarding a second level appeal within 30 days after receipt of the claimant's request of a second level review of an adverse benefit determination.

External Review

After a claimant has exhausted the internal appeals described above, the claimant may submit a request for an external review which satisfies U.S. Department of Labor regulations issued in connection with ERISA and Health Care Reform.

Standard External Review

The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four months after the date

of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether:

- The claimant had coverage under the Plan at the time the service or supply was provided;

- Whether the claimant has exhausted the Plan's internal appeal process unless not required to do so as described above; and

- Whether the claimant has provided all information and forms necessary to process the external review.

Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan shall assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan shall take action against bias and to ensure independence. Contracts shall be in place with at least three IROs. External reviews shall be rotated among the IROs. In addition, an IRO shall not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits.

- The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO shall make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information for the IRO to consider when conducting the external review.

- Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

- Upon any receipt of any information submitted by the claimant, the IRO must, within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.

- The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim "de novo" (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review including the claimant's medical records, the attending health care professional's recommendation, reports from appropriate health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider, the terms of the Plan, appropriate practice guidelines (including applicable evidence-based standards), any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law, and the opinion of the IROs clinical reviewer(s).

- The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.

- The IRO's decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the

health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial), the date the IRO received the assignment to conduct the external review and date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

- After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

Expedited External Review

The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility.

- Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external

review. The Plan must immediately send a written notice that meet the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.

- Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.

- The IRO shall provide notice of its decision in the same manner as a standard external review and shall do so as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Legal Actions

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-funded benefits under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim.

If the Plan fails to strictly adhere to the internal appeals procedures described in this section, the claimant will be deemed to have exhausted the internal appeal procedures and as a result, may immediately initiate an external review or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.

ADMINISTRATION

Plan Sponsor is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

With respect to the self-funded benefits, Plan Sponsor, as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan. However, the plan administrator may delegate claims administration for some or all of the self-funded benefits to a third party claim administrator. Such a third party claim administrator may be a named fiduciary for benefit appeals pursuant to the applicable benefit.

The fully-insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurers are the exclusive source of payment for the fully-insured benefits.

AMENDMENT OR TERMINATION

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor has the authority to amend or terminate the Plan or any benefit under the Plan at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. Participants will be informed of any material amendment affecting their coverages or changing the operation of the Plan.

HIPAA PRIVACY AND SECURITY RULES

This section applies to the health benefits under the Plan and is required by the privacy and security rules of HIPAA.

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

Subject to obtaining written certification (see below), the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event will Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.

- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

- Make available to a participant who requests access, the participant's PHI in accordance with 45 CFR §164.524.

- Make available to a participant the right to request an amendment to the participant's PHI and incorporate any amendments to the participant's PHI in accordance with 45 CFR §164.526.

- Make available to a participant who requests an accounting of disclosures of the participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.

- If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth below are followed.

- Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan Sponsor will ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Certification of Plan Sponsor

The Plan will disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth above.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or

- Modifying, amending or terminating the Plan.

Adequate Separation Between Plan and Plan Sponsor

- The employees, or classes of employees, listed in Plan Sponsor's HIPAA privacy policies and procedures will be given access to PHI.

- The access to and use of PHI by the individuals described above will be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.

- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the plan administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

- To comply with the HIPAA security rules, Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Plan Sponsor authorizes and directs the Plan, through the plan administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the HIPAA privacy rules.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the HIPAA privacy rules.

Definitions

For purposes of this section, the following terms have the following meanings:

- **"Business Associate"** means a person or entity who:
  - Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or
  - Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- **"Plan Administrative Functions"** mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans–such as dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an

authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.

- **"Protected Health Information"** or **"PHI"** means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a participant's information are considered to enable identification:

    - Names;
    - Street address, city, county, precinct, zip code;
    - Dates directly related to a participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;
    - Telephone numbers, fax numbers and electronic mail addresses;
    - Social Security numbers;
    - Medical record numbers;
    - Health plan beneficiary numbers;
    - Account numbers;
    - Certificate/license numbers;
    - Vehicle identifiers and serial numbers, including license plate numbers;
    - Device identifiers and serial numbers;
    - Web Universal Resource Locators (URLs);
    - Biometric identifiers, including finger and voice prints;
    - Full face photographic images and any comparable images; and
    - Any other unique identifying number, characteristic or code.

- **"Summary Health Information"** means information that may be individually identifiable health information:

- That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Employer has provided health benefits under a health plan; and

- From which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

GOVERNING LAW

The Plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as well as other various federal laws, including, but not limited to, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, HIPAA, FMLA, COBRA, USERRA and Health Care Reform, as well as certain state insurance laws. However, the Plan includes reference to certain benefits (specifically, voluntary dental, short-term disability, adoption assistance benefits, HSAs and dependent care flexible spending accounts) that are not subject to ERISA.

To the extent not preempted by ERISA, the Plan will be construed in accordance with the laws of the state of Michigan.

FORM 5500

The health and welfare benefits described in this Plan (except for the non-ERISA benefits) shall be considered a single plan for purposes of satisfying any obligation to file an annual Form 5500.

YOUR RIGHTS AS A PLAN PARTICIPANT

As a participant in the Plan, you are entitled to certain rights and protections under ERISA with respect to the benefits under the Plan that are subject to ERISA.

Information About the Plan and its Benefits

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the plan administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if 100 or more participants, 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 the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated Summary Plan Description and, if 100 or more participants, a copy of the latest annual report (Form 5500 Series). The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report if there are 100 or more participants in the Plan and the Plan is not funded solely through Employer's general assets. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review the rules governing your COBRA continuation coverage rights described elsewhere in this document.

Plan Fiduciaries

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

Enforcement of Rights

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

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

Assistance With Questions

If you have any questions about the Plan, you should contact the plan administrator. If you have any questions about this statement ("YOUR RIGHTS AS A PLAN PARTICIPANT") or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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 at 1-866-444-3272 or viewing its website at www.dol.gov/ebsa.

OTHER BASIC INFORMATION ABOUT THE PLAN

Plan Name:	Hope College Employee Benefit Plan
Benefits:	• Group Medical/Prescription Drug Benefit • Group Term Life/AD&D (base and supplemental) and Dependent Life Benefits • Group Long-Term Disability (base and optional) Benefit • Group Travel Accident Insurance Benefit • Employee Assistance Program • Medical Flexible Spending Accounts (under Employer's flexible benefit plan)
Name, Address and Telephone Number of Sponsoring Employer and Plan Administrator:	Hope College 100 East 8th Street, Suite 210 Holland, MI 49423 (616) 395-7811
Sponsoring Employer's Taxpayer Identification Number:	38-1381271
Plan Number:	501
Type of Plan:	Health and Welfare Benefits Plan providing the benefits described above. (In addition, Employer provides voluntary dental, voluntary vision, short-term disability, adoption assistance, HSAs and dependent care flexible spending account benefits which are not subject to ERISA and technically are not part of this Plan.)
Type of Administration:	The Plan is administered by the plan administrator. Certain self-funded benefit claims are processed by a third party claim administrator. Fully-insured benefit claims are processed and fully administered by the insurer.
Plan Administrator:	Employer/Plan Sponsor

Name and Address of Agent for Service of Legal Process:	Director of Human Resources Hope College 100 East 8th Street, Suite 210 Holland, MI 49423 (616) 395-7811 Service of process may also be made on the plan administrator.
Plan Year for Fiscal Record Purposes:	July 1 through June 30
Claim Administrator for Self-Funded Medical Benefit:	Blue Cross Blue Shield of Michigan 86 Monroe Center, N.W. Grand Rapids, MI 49503 (888) 890-5712 www.bcbsm.com
Claim Administrator for Self-Funded Prescription Drug Benefit:	CVS/caremark **For Paper Claims:** P.O. Box 52136 Phoenix, AZ 85072 **For Mail Service Claims:** P.O. Box 659541 San Antonio, TX 78265 (888) 321-4206 www.caremark.com
Insurer for Voluntary Dental Benefit:	Blue Cross Blue Shield of Michigan 600 E. Lafayette Blvd. Detroit, MI 48226-2998 (877) 671-2583 www.bcbsm.com
Insurer for Voluntary Vision Benefit:	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 (866) 939-3633 www.eyemedvisioncare.com

Insurer for Life, AD&D and Long-Term Disability Benefit:	The Lincoln National Life Insurance Company 8801 Indian Hills Drive Omaha, NE 68114-4066 (800) 423-2765 www.lincolnfinancial.com
Insurer for Group Travel Accident Insurance Benefit:	The Hartford P.O. Box 2999 Hartford, CT 06104-2999 (800) 523-2233
EAP Provider:	Employee Assistance Center 3351 Claystone Drive, S.E. Grand Rapids, MI 49546 (800) 227-0905

Signature

Plan Sponsor has signed the amended and restated Hope College Employee Benefit Plan, restated as of July 1, 2016.

HOPE COLLEGE

Dated: _____ By_____

Title _____