

GRINNELL COLLEGE
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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OF
GRINNELL COLLEGE
FLEXIBLE BENEFITS PLAN

Dear Participant:

Grinnell College has adopted the Flexible Benefits Plan for the exclusive benefit of you and all participating employees. Its purpose is to reward you for loyal service by enabling you to select certain employee benefits that will best fit your individual needs in a tax-effective manner. If you elect to use the benefits of the Flexible Benefits Plan, you may realize savings of income taxes and social security taxes. Grinnell has established this Plan with the intention that it will be continued indefinitely, but Grinnell does reserve the power to amend or terminate this Plan at any time.

The Plan is a written document which sets forth the provisions of this fringe benefit program. In order to find out how the program affects you and your family, you may read the actual document (copies are available to you at the offices of Grinnell College, the Plan Administrator, during regular business hours). However, in order to help you understand this program, we have condensed your Plan into a series of questions and answers which summarize and explain the provisions and benefits available under the program. If you want additional information about the Plan, please contact Jim Mulholland at the address or phone number listed in the Important Information Section.

This summary is not meant to interpret, extend or change the Plan in any way. In case of a conflict between this summary and the actual provisions of the Plan, the provisions of the Plan will govern your rights and benefits.

IMPORTANT INFORMATION

Effective Date: January 1, 2001

Plan Year:	January 1 - December 31
Benefit Option(s):	Pre-tax premium payment for health and dental plans, dependant care assistance, medical expense reimbursement
Employer:	Grinnell College
Address:	Office of the Treasurer Grinnell, Iowa 50112-1690
Telephone:	(641) 269-3500
Employer Identification Number:	42-0680387
Plan Number:	510
Plan Administrator: Contact(s) at Plan Administrator:	Grinnell College Jim Mulholland
Address:	Office of the Treasurer Grinnell, Iowa 50112-1690
Telephone:	(641) 269-3500

The Plan Administrator is designated as agent for all purposes of legal process.

ELIGIBILITY

1. When am I eligible to join the Plan?

All employees of Grinnell College who work at least twenty (20) hours per week during the academic year on a regular or term appointment basis are eligible to participate in the Plan. Seasonal employees who normally work less than six (6) months per year are not eligible to participate in the Plan.

An eligible employee employed on the Effective Date who elects to participate will become a Participant on the Effective Date.

Any other employee who elects to become a Participant will become a Participant in the Plan on the first day of the month coincident with or immediately following the date the employee meets the eligibility requirements. Any employee who does not elect to participate in the Plan on the date the employee first becomes eligible may later elect to begin participating as of the first day of any subsequent Plan Year except for a Change in Status or upon the occurrence of an event described in Question 10 herein.

CONTRIBUTIONS AND BENEFITS

2. What are the benefits available to me?

An employee may choose under this Plan to receive the employee's full compensation for any Plan Year in cash or to have a portion of it applied by Grinnell College toward the cost of one or more of the Benefit Options listed above in the Important Information Section.

MEDICAL EXPENSE REIMBURSEMENT ACCOUNT

The Medical Expense Reimbursement Account enables you to pay expenses which are not covered by an insured or self-insured medical plan and save taxes at the same time. The account only allows reimbursement of out-of-pocket expenses incurred by you and your dependents which meet the criteria for deductibility as medical expenses under Code Section 213(d).

During the course of the Plan Year, you may submit requests for reimbursement of qualified medical expenses you have incurred during the Plan Year. For this purpose, expenses are incurred when you are provided with the medical care which gives rise to the medical expenses, and not when you are formally billed or charged for, or pay for the medical care. Qualified medical expenses are those medical, dental and vision expenses which are incurred on an irregular basis during the Plan Year. Grinnell College will provide you with acceptable forms for submitting these requests for reimbursements. If the request qualifies as a benefit or expense that the Plan has agreed to pay for, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are not subject to Federal income tax or withholding.

Any monies left in your Reimbursement Account at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in your Reimbursement Account if you do not fully use the contributions that have been made, it is important that you decide how much to place in the Reimbursement Account carefully and conservatively. Remember, you must decide how much to place in the Medical Expense Reimbursement Account before the Plan Year begins. You want to be as certain as

you can that the amount you decide to place in the Medical Expense Reimbursement Account will be used up entirely.

The maximum amount of Flexible Dollars that you can allocate to your Medical Expense Reimbursement Account each Plan Year shall be determined by the Employer prior to the beginning of each Plan Year and such amount for the first Plan Year shall not exceed \$3,000.00 per Participant.

DEPENDENT CARE EXPENSE REIMBURSEMENT ACCOUNT

The Dependent Care Expense Reimbursement Account enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax Flexible Dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse is disabled or goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses". Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, so long as care is provided for more than six individuals. The facility must comply with applicable state and local laws.
- An Educational Institution for pre-school children or children in kindergarten. For older children, only expenses for non-school care are eligible.
- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone who you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify under our Plan. The law places limits on the amount of money that you can contribute to the Dependent Care Assistance Account. Also, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. If you are uncertain, you should ask your tax adviser which is better for you.

During the course of the Plan Year, you may submit requests for reimbursement of qualified dependent care expenses you have incurred during the Plan Year. Grinnell College will provide you with acceptable forms for submitting these requests for reimbursements. If the request qualifies as a benefit or expense that the Plan has agreed to pay and if you have sufficient Flexible Dollars in your Dependent Care Expense Reimbursement Account, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are not subject to Federal income tax or withholding.

Any monies left in your Dependent Care Expense Reimbursement Account at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in your Reimbursement Account if you do not fully use the contributions that have been made, it is important that you decide how much to place in the Reimbursement Account carefully and conservatively. Remember, you must decide how much to place in the Dependent Care Reimbursement Account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in the Dependent Care Reimbursement Account will be used up entirely.

The maximum amount of Flexible Dollars that you can allocate to your Dependent Care Reimbursement Account each Plan Year is \$5,000 for a single parent or a married parent filing a joint income tax return and \$2,500 for a married parent filing a separate income tax return. The \$5,000 limit for a married parent filing jointly is a combined limit applicable to both parents. Each parent does not have a separate \$5,000 limit.

PRE-TAX PREMIUM ACCOUNT

The Pre-Tax Premium Account allows you to use the tax-free Flexible Dollars to pay your share of the premiums under the group medical and dental plans maintained by Grinnell College.

The right is reserved for the Plan Administrator to terminate, suspend, withdraw or modify Plan benefits in whole or in part at any time, subject to the applicable provisions of the insurance contracts or HMOs, if any, providing benefits described above. Any failure of insurance or HMO benefits, whether due to Grinnell College's negligence, gross neglect, or otherwise, including but not limited to failure to enroll a participant or pay premiums, shall not result in any liability by Grinnell College to a participant. Your coverage shall terminate when you leave employment, if you are no longer eligible under the terms of any insurance or policies or HMOs, or when insurance/HMO coverage terminates, whichever happens first.

Any benefits to be provided by insurance or an HMO shall be provided only after (1) the participant has provided the Plan Administrator the necessary information to apply for benefits, and (2) the coverage is in effect for such participant.

3. Who makes contributions to the Plan?

You will have the option to enter into a compensation reduction agreement with Grinnell College whereby you may irrevocably elect to redirect a portion of your compensation for the Plan Year, and have this amount, called "Flexible Dollars", contributed by Grinnell College to a separate benefits account to be used to provide benefits to you under this Plan. Once you have signed the agreement, you will not be able to change the amount of compensation redirected during the Plan Year unless you have a Change in Status, experience the occurrence of an event described in Question 10 herein, or you terminate from service.

The total Flexible Dollars you elect to have contributed to the Plan during a year will be withheld in equal installments from each of your regular paychecks during that year.

In addition to Flexible Dollars resulting from your compensation reduction election, the Employer may, under certain circumstances, contribute Flexible Dollars to the Plan for your benefit. The Employer will advise you of its contribution, if any, prior to the beginning of a Plan Year. An employee, other than a member of a collective bargaining unit, may choose to receive any Flexible Dollars contributed by Grinnell College in cash or to apply those Flexible Dollars toward any of the benefit options available under the Plan.

4. If I elect to redirect my compensation, how can this benefit me?

This can best be shown by the following example:

Employee A is married and has two children. Employee A is an employee at Example Company and earns \$20,000 a year.

Employee A decided to enroll in the Example Company Flexible Benefit Plan. Employee A elects to redirect \$1,500 (\$125 per month) of current compensation into the Plan to purchase benefits which would otherwise be purchased with after-tax dollars.

With the Plan, Employee A is able to pay for the benefits with dollars that are not taxed. Employee A's disposable income with and without the Plan is shown below:

	<u>With Compensation Redirection</u>	<u>Without Compensation Redirection</u>
Gross salary	\$ 20,000	\$ 20,000
Less: Compensation used to purchase benefits	<u>1,500</u>	<u>-</u>
Taxable salary	<u>\$ 18,500</u>	<u>\$ 20,000</u>
Federal income tax	\$ 2,779	\$ 3,004
Social security tax	<u>1,415</u>	<u>1,530</u>
Total taxes	<u>\$ 4,194</u>	<u>\$ 4,534</u>
Salary after taxes	14,306	15,466
Cost of benefits	<u>\$ -</u>	<u>\$ 1,500</u>
 DISPOSABLE INCOME	 <u>\$ 14,306</u>	 <u>\$ 13,966</u>
 NET SAVINGS <u>WITH PLAN</u>	 <u>\$340</u>	

Employee A receives \$340 (\$14,306 minus \$13,966) more per year in disposable income if Employee A elects to participate in the Plan.

5. If I elect to redirect my compensation, how does this affect my social security benefits?

Participation in the Flexible Benefits Plan will normally result in Grinnell College and yourself making lower contributions to the federal social security system. This is likely to reduce your social security contributions and could reduce your benefits.

6. How do I elect to redirect my compensation and have it applied toward the cost of one or more of the optional benefits?

You must specify the desired optional benefits on the appropriate election form(s). These forms will be provided to you at the time employment commences and approximately 30 days prior to the commencement of each Plan Year.

7. What is the deadline to elect one or more of the optional benefits?

Each election form should be completed and returned to Grinnell College before the beginning of the Plan Year for which your compensation redirection agreement will apply.

8. If I am a new participant, when can I make my compensation reduction election?

Grinnell College will provide you with the necessary election forms when you become eligible to participate. These forms must be completed and returned to Grinnell College before the beginning of the first pay period for which your agreement will apply.

9. What happens if I fail to return a completed election form to Grinnell College by the deadline?

If you do not submit an election form to Grinnell College in the year which you first become eligible to participate, you will be deemed to have elected to receive your full compensation for that year in cash and you will not have the opportunity to participate until the next Plan Year except for a Change in Status or upon the occurrence of an event described in Question 10 herein.

10. Can I change or revoke my elections during the Plan Year?

In general, your election is irrevocable for the duration of the Plan Year. However, it can be changed due to a Change in Status or upon the occurrence of certain events if you notify Grinnell College within 30 days of the change event. Any new election you make will be effective on the date prescribed by Grinnell College, but not earlier than the first pay period beginning after the election form is completed and returned to Grinnell College. However, an election change on account of birth, adoption or placement for adoption will apply as of the date of such event and an election change on account of marriage will apply as of the first day of the month after an election form is completed provided that notice of the marriage, birth, adoption or placement for adoption is received by Grinnell College within 30 days after such event. In all cases, any election revocation or change must be consistent with the reason the change is permitted.

You may revoke an election and make a new election if a Change in Status occurs which affects eligibility for coverage and the election change corresponds with the effect on eligibility. A Change in Status occurs upon events such as a change in marital status, number of dependents, employment status, work schedule or residence or work site, as well as cases where a dependent first satisfies or ceases to satisfy the requirements for unmarried dependents.

You may also revoke your election and make a new election if you, your spouse and/or dependent(s) qualify for special enrollment under a health plan. Under the Health Insurance Portability and Accountability Act, group health plans are generally required to permit individuals to be specially enrolled for coverage following a loss of other health coverage or when a person becomes the spouse or dependent of an employee through birth, marriage, adoption or placement for adoption.

Furthermore, upon receipt of a court order, such as a qualified medical child support order under ERISA § 609, the Plan may allow you to change your election to provide coverage for a child if required by such order or to make an election to cancel coverage for a child if the order requires the former spouse to provide coverage and that coverage is, in fact, provided.

Finally, if an employee, spouse or dependent becomes entitled to or loses eligibility under Medicare or Medicaid, the Plan may allow you to make an election change to cancel, reduce or increase your coverage, your spouse's coverage and/or your dependents' coverage under the accident or health plan.

Election changes (except changes to your Medical Expense Reimbursement Account) will also be permitted where there has been a significant change in your health coverage or your spouse's health coverage attributable to your spouse's employment, in the event of a significant increase or decrease in your costs with respect to any medical plan sponsored by Grinnell College in the event of change in coverage under another employer plan or a loss of coverage under other group health coverage. If the

employee portion of premiums for elected coverages is increased or decreased during the Plan Year, Grinnell College is authorized to automatically adjust your compensation reduction election to reflect the increase or decrease.

If you cease to be a participant in the Plan during a Plan Year other than due to a Change in Status or upon the occurrence of a specified event, you may not re-elect coverage for the remaining portion of the Plan Year. Once you have ceased to participate in and to make contributions to the Plan, premium payments or contributions for medical or other elected coverage will cease. Also, your ability to submit claims depends on which of the available benefits you have elected. With respect to the Medical Expense Reimbursement Account, you may only submit claims for medical expenses incurred prior to the date contributions cease and no additional Flexible Dollars will accumulate in the Account, unless you have made the total payments required for coverage during the entire Plan Year. With respect to the Dependent Care Expense Reimbursement Account, you may continue to submit claims for dependent care expenses incurred during the remainder of the Plan Year within which contributions cease but no additional Flexible Dollars will accumulate in the Account. Premium payments or contributions for medical or other elected coverages will cease.

11. Once I have enrolled, do I have to complete a new election form each year?

Yes. A new election form must be completed for each Plan Year.

12. What happens to my elections if I am no longer eligible to participate in the Plan?

Elections made under this Plan will automatically terminate on the date on which you cease to be a participant in the Plan.

However, if you were participating in the Medical Expense Reimbursement portion of the Plan (or were participating on the day your FMLA leave commenced), you may have the right under COBRA to elect a temporary extension of health coverage (called "continuation coverage") if a Qualifying Event occurs. If you are on FMLA leave and you fail to return to active employment by the end of the leave period, the Qualifying Event is considered to occur on the last day of FMLA leave. The last day of FMLA leave is also the beginning of the maximum COBRA coverage period.

If your participation ceases due to a Qualifying Event (i.e. reduction in your hours of employment or because you terminate your employment for reasons other than gross misconduct on your part), you can elect COBRA coverage. Specifically, COBRA continuation coverage may be available with respect to participation in the Medical Expense Reimbursement Account. However, COBRA continuation coverage may not be available to a qualified beneficiary for any plan year after the plan year in which the Qualifying Event occurs if:

- (1) the Medical Expense Reimbursement Account is an excepted benefit under the Health Insurance Portability and Accountability Act (i.e. the maximum reimbursement available under the Account is not greater than two times the employer's salary reduction election and there is other health coverage available through the Employer), and
- (2) the maximum amount the employee must contribute for a full year is at least the maximum reimbursement the employee can receive for that year.

COBRA continuation coverage may not be available at all if, in addition to the above requirements, as of the date of the qualifying event the maximum reimbursement available to the qualified beneficiary under the Account for the remainder of the plan year is not more than the maximum amount the plan could require as payment for the remainder of the year to maintain coverage under the Account.

If you are the spouse of an employee covered by the Medical Expense Reimbursement portion of the Plan, you have the right to choose continuation coverage for yourself if you experience a Qualifying Event and you lose coverage under that portion of the Plan for *any* of the following four reasons:

- (1) The death of your spouse;
- (2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- (3) Divorce or legal separation from your spouse; or
- (4) Your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee, the child has the right to continuation coverage if the child experiences a Qualifying Event and loses coverage for *any* of the following reasons:

- (1) The death of a parent;
- (2) A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with Grinnell College;
- (3) A parent becomes eligible for Medicare; or
- (4) The dependent ceases to be a "dependent child."

Under the continuation coverage law, you or a family member have the responsibility to inform Grinnell College of a divorce, legal separation or a child's losing dependent status.

A child who is born to or placed for adoption with the covered employee during a period of continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Grinnell College of the birth or adoption.

When Grinnell College receives notice one of these events has happened, you will be notified that you have the right to choose continuation coverage. Under the continuation coverage law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform Grinnell College you want continuation coverage.

If you do not choose continuation coverage, your medical reimbursement coverage will end.

If you choose continuation coverage, Grinnell College must give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to an employee or family member in your situation.

The law provides you an opportunity to maintain continuation coverage for 3 years, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. The 18 months may be extended for all qualified beneficiaries (as that term is defined in COBRA) to 29 months if a determination is made by the Social Security Administration that any one of the individuals who become a qualified beneficiary due to the same Qualifying Event is disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage (or within the first 60 days after a child's birth or placement for adoption), provided, that the qualified beneficiary notifies the Plan Administrator within 60 days of that determination and before the end of the original 18-month period. The 11-month extension (from the 18-month maximum coverage period to a 29-month maximum coverage period) is available to each qualified beneficiary if one or all of the individuals who become qualified beneficiaries due to the same Qualifying Event become disabled. Each qualified beneficiary has an independent right to the disability extension.

If the disabled individual recovers from the disability during the period beginning with the 19th month and ending at the end of the 29th month, COBRA coverage will terminate as of the month that begins more than 30 days after the date of the final determination under the social Security Act that the qualified beneficiary is no longer disabled. If the recovery takes place before the beginning of the 19th month, the disabled individual will continue to have COBRA coverage until the end of the 18-month maximum coverage period.

However, the law also provides your continuation coverage may cease for *any* of the following five reasons:

- (1) Grinnell College no longer provides group health coverage to any of its employees;
- (2) You do not pay the premium for your continuation coverage;
- (3) You become an employee covered under another group health plan;
- (4) You become eligible for Medicare;
- (5) You were divorced from a covered employee, subsequently remarry and your new spouse's group health plan covers you.

You do not have to show you are insurable to choose continuation coverage. However, under the continuation coverage law, you may have to pay all or part of the premium for your continuation coverage.

13. What happens to my benefits and elections if I take a leave of absence?

If you take a leave of absence due to disability, family or medical leave, or any other reason approved by the Employer, you shall have the option to:

- (a) Revoke or change your Compensation Reduction Election based on a Change in Family Status. In no event may your election change reduce the Medical Expense Reimbursement benefit below the amount of benefit used as of the date of the election change.
- (b) Prepay, on a pre-tax or an after-tax basis, all or a portion of the Flexible Dollar amounts that would normally have been contributed during the period of time you expect to be on leave. You may allocate the prepayment amount to provide increased, decreased or different benefits as specified on your Prepayment Election form. In no event will a change in your election affect the amount of the Employer's share of the cost of benefits selected. In fact, a full or complete reduction in the amount of Flexible Dollars allocated toward a benefit will result in a corresponding reduction in the benefit itself, except in certain circumstances where the unpaid leave is taken pursuant to the federal Family and Medical Leave Act.
- (c) Continue to pay, on a pre-tax or an after-tax basis, the Flexible Dollar amounts at the same rate and in the same manner as prior to your leave (i.e. every payroll period). If your payment is more than thirty (30) days late, the Employer may drop your coverage or may continue to pay for your share of the coverage at the Employer's discretion. However, your Employer may recover from you the cost of any payments made to maintain your coverage unless you do not return to work and such failure to return to work is a result of circumstances beyond your control.

Upon return from unpaid leave, your original Compensation Reduction Election will recommence for the duration of the Plan Year except for a Change in Status or upon the occurrence of an event described in Question 10 herein.

Regardless of the payment option selected, as long as you continue to make contributions to the Plan, the full amount of coverage elected under the medical expense reimbursement portion of the Plan, less any reduction under 13(a) or (b) and less any prior reimbursements, will be available to you at all times, including during an unpaid FMLA leave period. However, if you cease to make contributions so that your coverage under this portion of the Plan terminates while on leave, you are not entitled to receive reimbursement for claims incurred during the period when the coverage was terminated. If you elect to reinstate coverage upon return from leave, your coverage under this portion of the Plan for the remainder of the Plan Year will be equal to your original Compensation Reduction Election for the 12-month period of coverage prorated for the period when coverage was terminated during leave and reduced by prior reimbursements.

14. What happens when a medical child support order is issued with respect to the medical coverage provided through this Plan?

Upon receipt of a medical child support order, the Employer will determine, in accordance with a written and established procedure, whether the order is qualified. If the order is found to be a Qualified Medical Child Support Order, the Plan will provide medical coverage to your child without regard to Plan limitations which may require that you have custody of the child or that the child be designated as your dependent for tax purposes. The child will have medical coverage as of the date of the order, not limited or delayed for either a pre-existing condition or a waiting period. Reimbursements of benefit payments will be made to the child or the child's custodial parent. A Qualified Medical Child Support Order is an exception to the general rule that your benefits under the Plan cannot be assigned or alienated.

15. What if I don't spend all Plan contributions?

Any Flexible Dollars which are not used to pay for benefits you select will be forfeited back to Grinnell College to defray administrative costs of the Plan. Because this is possible, you should be careful to authorize only those amounts necessary to pay for the coverage you elect.

16. How do I submit a claim under this Plan?

Claims for reimbursement of expenses incurred during a Plan Year may be submitted at any time during the Plan Year or during the first 90 days of the following Plan Year regardless of amount. Claims shall also be paid to the extent of available Flexible Dollars allocated to the appropriate benefit and shall only be paid out of Flexible Dollars for the Plan Year in which the claim was incurred. Unless you have made all payments required for coverage during the entire Plan Year, Flexible Dollars allocated to your Medical Expense Reimbursement Account shall cease to be available to pay claims for expenses incurred after the date required payments cease if you, for any reason (including termination from service) cease to make the required payments with respect to the benefit. Claims incurred prior to the time you become a Participant for purposes of receiving Flexible Dollars and after the Plan Year in which you cease to be a Participant shall not be covered by this Plan. However, claims must be submitted on forms approved by the Employer, accompanied by such written statements from independent third parties, bills, or other proof of incurring the expense as the Employer may require. Payment of covered claims may be made directly to you or, at the Employer's discretion, directly to the person or entity providing or supplying the services or insurance which are the subject of the claim. The administrator will pay claims during the Plan Year to the extent that Flexible Dollars are available. After all Flexible Dollars have been exhausted, claims remaining unpaid at the Plan Year end will be canceled. In no event can these claims be resubmitted the next Plan Year, nor are any unpaid claims a liability of the Employer.

17. **What can I do if my claim is denied?**

If you believe you are being denied any rights or benefits under the Plan, you may file a claim in writing with the Plan Administrator. If any such claim is wholly or partially denied, the Plan Administrator will notify you of its decision in writing. Such notification will be written and will contain the following:

- (a) Specific reasons for the denial
- (b) Specific reference to pertinent Plan provisions
- (c) A description of any additional material or information necessary for you to perfect such claim and an explanation of why such material or information is necessary
- (d) Information as to the steps to be taken if you wish to submit a request for review.

Such notification will be given within 90 days after the claim is received by the Plan Administrator (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given by you within the initial 90-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and you may request a review of your claim.

Within 60 days after the date on which you receive a written notice of a denied claim (or, if applicable, within 60 days after the date on which such denial is considered to have occurred), you (or your duly authorized representative) may

- (a) file a written request with the Plan Administrator for a review of your denied claim and of pertinent documents, and
- (b) submit written issues and comments to the Plan Administrator.

The Plan Administrator will notify you of its decision in writing. Such notification will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Plan Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Plan Administrator to hold a hearing, and if written notice of such extension and circumstances is given to you within the initial 60-day period). If the decision on review is not made within such period, the claim will be considered denied.

18. **What are my rights under the law?**

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

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements,

and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Chicago Regional Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, at 200 West Adams Street, Suite 1600, Chicago, Illinois 60686 or by telephone at (312) 353-0900 or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

19. Can the Plan be terminated or amended?

Yes. Grinnell College reserves the right to terminate, suspend, withdraw or modify Plan benefits in whole or in part at any time by action of its Board of Directors, subject to the applicable provisions of any insurance contracts providing benefits described above. However, no such change will cause you to forfeit any funds you had contributed to the Plan prior to the change. In addition, any insurance carrier may cancel insurance policies for under-enrollment or for non-payment of premiums in certain circumstances. Any failure of insurance benefits, whether due to Grinnell College's negligence, gross neglect, or otherwise, including, but not limited to, failure to enroll a participant or to pay premiums shall not result in any liability by Grinnell College to a participant. Your coverage shall terminate when you leave employment if you are no longer eligible under the terms of any of the insurance policies or benefits provided by this Plan, or when insurance coverage terminates, whichever happens first.

Any benefits to be provided by insurance shall be provided only after (1) you have provided the Plan Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

Date: June, 2001

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