

Goshen College FlexChoice Account Plan

Summary Plan Description

Amended July 1, 2011

Table of Contents

Part I, Introduction	3
Part II, Definitions	3
Part III, Eligibility — Who Can Enroll in the Plan	5
Part IV, Enrollment in the Plan	6
Part V, Reimbursement Accounts	11
Part VI, Premium Expense Benefit	14
Part VII, How To Request Reimbursement.....	14
Part VIII, When a Reimbursement Request is Denied	16
Part IX, Termination of Plan Participation.....	17
Part X, Continuation of Coverage	17
Part XI, Provision of Protected Health Information to Plan Sponsor.....	18
Part XII, Administration of the Plan.....	20
Part XIII, Other Important Points	22
Part XIV, Miscellaneous Plan Information	25
Appendix A	27

Part I, Introduction

This summary plan description describes the benefits provided under the Goshen College FlexChoice Account Plan (FlexChoice) for eligible employees of Goshen College. This plan is intended to qualify as a flexible benefits plan under Section 125 of the Internal Revenue Code of 1986, as amended (Code). This plan amends the flexible benefits plan previously established by Goshen College for eligible employees. The provisions of this amended plan are effective July 1, 2011.

Through FlexChoice, eligible employees have the opportunity to receive medical expense and dependent care reimbursement benefits and pay the required premiums on a pretax basis. The medical expense reimbursement benefit of FlexChoice is intended to qualify as a medical reimbursement plan under Section 105 of the Code. The dependent care reimbursement benefit of FlexChoice is intended to qualify as a dependent care assistance plan under Section 129 of the Code.

The premium expense benefit of FlexChoice gives eligible employees the opportunity to pay the required premiums for coverage under the group health plans sponsored or provided by Goshen College on a pretax basis.

Payment on a pretax basis means the required premiums for group health plan coverage and reimbursement benefits are deducted from an employee's compensation through salary reduction before any federal income taxes (as well as FICA taxes) are deducted. This means the employee pays less in income taxes, although his or her gross pay remains the same. State tax treatment may differ from federal tax treatment depending on the tax laws of the state in which the employee's compensation is earned.

It is important to realize that future Social Security benefits may be slightly reduced because participation in FlexChoice reduces the amount of contributions both the employee and the employer pay into the Social Security system.

This summary plan description will tell you how you can participate in the plan, how the plan works, and other important information about the benefits provided under the plan. Please read it carefully.

If you have questions about FlexChoice or how the plan operates, talk to the plan representative. The name of the plan representative is listed in *Part XIV*.

If you have questions about the tax consequences of participating in FlexChoice, consult your tax advisor.

The reimbursement benefits of this plan will be administered by a FlexChoice administrator who is trained in the benefits offered by FlexChoice. The FlexChoice administrator's name, address, and phone number are:

Everence Insurance Company
P.O. Box 483
Goshen, IN 46527-0483
(574) 533-9511 or (800) 348-7468

Part II, Definitions

The following words and terms are used in this summary plan description. When used, this is what they mean.

Annual benefit election period — The 30-day benefit election period that begins May 15 and ends June 15 each plan year, during which an eligible employee is given the opportunity to confirm, revoke, or change the benefit elections and salary reduction authorization made for the current plan year with respect to a new plan year.

Benefit election period — The 30-day period of time that immediately follows a qualifying event, during which an eligible employee is given the opportunity to elect the benefits he or she wishes to participate in and authorize payment of the required premiums for the benefit elections on a pretax basis through salary reduction.

Benefit(s) — Those qualified benefits available to a plan participant under this plan which are described in Appendix A, as substituted, added, subtracted, and/or amended from time to time.

Calendar year — The 12-month period from Jan. 1 through Dec. 31 of any year.

Code — The Internal Revenue Code of 1986, as enacted and as may be amended from time to time, together with all lawful rules and regulations issued under it.

Compensation — The annual earnings received by an employee from the employer, excluding bonuses, overtime, severance pay, expense reimbursement, and any form of non-cash compensation, but including amounts by which the employee elects to reduce his or her compensation to make contributions to a Code Section 401(k), 403(b), 408(k), or 457(b) plan.

Dependent — For purposes of this plan, a dependent for a plan year is as follows:

1. For the premium expense and medical expense reimbursement benefits, a dependent is:
 - a. An employee's spouse (as defined in this *Part II*);
 - b. An individual who meets the definition of dependent as defined in Code Section 152, determined without regard to subsections (b)(1), (b)(2), or (d)(1)(B); and
 - c. An employee's child (as defined in Code Section 152(f)(1)) who has not attained age 26.

Any child of parents who are divorced, legally separated, or live apart at all times during the last six months of the calendar year (whether or not they are or were married), is treated as a dependent of both the custodial and noncustodial parent if the following conditions are met:

- a. One or both parents have custody of the child for more than one-half of the calendar year;
- b. The parents together provide more than one-half of the child's support for the calendar year; and
- c. The custodial parent releases claim to the income tax dependency exemption for the child to the noncustodial parent in a written declaration.

Notwithstanding the above, medical expense reimbursement benefits shall be provided in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of dependent.

2. For the dependent care reimbursement benefit, a dependent must be a qualifying individual. A qualifying individual is any of the following:
 - a. A dependent, as defined in Code Section 152, who is under the age of 13 and the employee's qualifying child, as defined in Code Section 152(c);
 - b. A dependent, as defined in Code Section 152, without regard to subsections (b)(1), (b)(2), or (d)(1)(B), who is physically or mentally incapable of self-care and lives with the employee for more than one-half of the year; and
 - c. The employee's spouse who is physically or mentally incapable of self-care and who lives with the employee for more than one-half of the year.

Election Form — The form provided by the FlexChoice administrator for the purpose of allowing an eligible employee to elect, during a benefit election period, the benefits he or she wishes to participate in and authorize payment for such benefit elections on a pretax basis through salary reduction.

Employee — Any individual who is employed by the employer on a regular full-time or part-time basis (as outlined in *Part III*) in a legal employer-employee relationship, is a common-law employee of the employer, and is on the employer's W-2 payroll. For purposes of this plan, *employee* does not include independent contractors, self-employed individuals, temporary employees, or casual employees, whether or not any such persons are on the employer's W-2 payroll.

Employer — Goshen College, Inc., an Indiana 501(c)(3) non-profit corporation dba Goshen College, with principal offices located at 1700 S. Main Street, Goshen, Indiana.

Group health plan — The plan or plans the employer sponsors and maintains for its employees (and their dependents), providing major medical, dental, vision, specified health, supplemental accident, and supplemental cancer benefits through a group insurance policy or policies or self-funded arrangement(s), which plan(s) qualify as an accident or health plan under Code Section 106 or a medical reimbursement plan under Code Section 105 (other than a long-term care insurance plan). The employer may substitute, add, subtract, or revise at any time the menu of such plans, and any such substitution, addition, subtraction, or revision will be reflected on the *Election Form* or otherwise communicated to plan participants, and will automatically be incorporated by reference under this plan. The specific coverage(s) elected by the employee are considered his or her group health plan for purposes of this plan.

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

HIPAA also includes regulations on privacy and confidentiality of protected health information of plan participants, outlined in 45 CFR §160 and §164, Subparts A and E, and security of electronic protected health information, outlined in 45 CFR §160 and §164, Subparts A, C, and D, that place restrictions on how a group health plan may use and disclose personal health information of plan participants.

Plan — The Goshen College FlexChoice Account Plan as set forth in this summary plan description and as amended from time to time.

Plan administrator — The person or entity that maintains the records of the plan, administers the plan, has discretionary authority to interpret the provisions of the plan, and makes all decisions necessary or proper to carry out the terms of the plan. The plan administrator may delegate its responsibilities to other persons or entities. The plan administrator for this plan is the employer.

Plan participant — A person who has met the eligibility requirements of this plan as a regular full-time or part-time employee of Goshen College, as outlined in *Part III*, and is enrolled in and receiving benefits under the plan.

Plan year — The 12-month period that begins July 1 and ends June 30. The plan year is the plan's fiscal year and the coverage period for the benefits provided under the plan.

Premium — The amount a plan participant is required to pay for the type and level of coverage under each benefit offered through FlexChoice that he or she elects to participate in.

Qualified benefit — Any benefit excluded from the employee's taxable income under Chapter 1 of Subtitle A of the Code (other than Sections 106(b), 117, 124, 127, or 132) and any other benefit permitted by regulation. Any product that is advertised, marketed, or offered as long-term care insurance is not a qualified benefit under this plan.

Qualified Medical Child Support Order — A medical child support order that:

1. Creates or recognizes the existence of a child's right to, or assigns to a child, the right to receive benefits for which a participant is eligible under the plan;
2. States the name and last known mailing address of the plan participant and the name and mailing address of each child (alternate recipient) covered by the order;
3. Contains a reasonable description of the type of coverage to be provided;
4. Specifies the period to which such order applies;
5. Identifies the plan to which such order applies; and
6. Does not require the plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a state law as described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Salary reduction — The amount by which a plan participant's compensation is reduced on a pretax basis and applied by Goshen College according to the terms of this plan, to pay the required premium(s) for the type and level of coverage under each benefit offered through FlexChoice that the plan participant elects to participate in.

Spouse — The person who is legally married to an employee (as determined under applicable state law) while the employee is a participant in this plan and who is treated as a spouse under the Code. *Spouse* does not include an individual who is legally separated from the employee.

You, your — You, as the employee of Goshen College who is enrolled in and participating in this plan and to whom this summary plan description is issued.

Part III, Eligibility — Who Can Enroll in the Plan

You are eligible to participate in this plan if you are employed by Goshen College as a:

1. Regular full-time* employee;
2. Short-term, full-time* employee with a fixed contract; or
3. Part-time employee working at least 50 percent of full-time* each year.

*Full-time is determined as follows:

- Staff and administrative faculty – 40 hours per week
- Teaching faculty – teaching load of 24 credit hours per academic year

Part IV, Enrollment in the Plan

A. Initial Enrollment

To enroll in the plan when you first become eligible, you must complete, sign, and return an *Election Form* to the plan representative as part of the hiring process or during the 30-day benefit election period that begins on your first day of employment as a regular full-time or part-time employee of Goshen College, as outlined in *Part III*.

The *Election Form* allows you to elect your choice of the following options:

1. Participation in FlexChoice;
2. Waiver of participation in FlexChoice;
3. The specific benefits offered through FlexChoice you wish to participate in;
4. The type and level of coverage under each specific benefit you elect to participate in; and
5. Your authorization of salary reduction to pay the required premium for each benefit you elect to participate in.

The benefit elections and salary reduction authorization you indicate on the *Election Form* will be effective the first day of the payroll period that coincides with or follows the day you meet the eligibility requirements for participating in the plan **and** return the completed *Election Form* to the plan representative.

Shortly after returning the *Election Form* to the plan representative, you will receive a verification letter listing your reimbursement benefit elections.

Your benefit elections will remain in effect for the entire plan year and cannot be revoked or changed, except as outlined below in *Part IV, Section G*.

Each plan year, to continue participating in FlexChoice, you must complete a new *Election Form* as outlined in *Part IV, Section B*.

If you elect to waive participation in FlexChoice when you first become eligible, or if you do not return the completed *Election Form* to the plan representative prior to the last day of the benefit election period, you will have to wait until the following plan year before you have another opportunity to participate in this plan.

B. Annual Benefit Election Period

Each year the plan provides a benefit election period between May 15 and June 15. During this period, eligible employees are given the opportunity to confirm, revoke, or change the benefit elections and salary reduction authorization made for the current plan year with respect to the new plan year.

The plan representative will provide an *Election Form* to each eligible employee each year at the beginning of the annual benefit election period. The *Election Form* must be completed, signed, and returned to the plan representative prior to the last day of the annual benefit election period. The benefit elections you make on the *Election Form* will be effective the first day of the new plan year (July 1). The salary reduction you authorize to pay the premium(s) for your benefit elections will begin the first full payroll period of the new plan year.

If you do not complete, sign, and return an *Election Form* for a new plan year to the plan representative prior to the last day of the annual benefit election period, you will be considered to have made the following elections:

1. **Premium expense benefit — you will be considered to have elected the same types and level of group health plan coverage for the new plan year as you elected for the plan year just ending. If the annual premium for any group health plan is increased or decreased, your salary reduction authorization will automatically be adjusted to reflect that change.**
2. **Reimbursement benefits — you will be considered to have elected not to participate in the medical expense and dependent care reimbursement benefits for the new plan year and will have to wait until the following plan year before you have another opportunity to elect to participate in these benefits.**

C. Change in Hours

If you are already an employee of Goshen College but have not met eligibility requirements for participating in the plan, you may enroll immediately following your first eligibility.

If you increase your hours so that you regularly work at least 50 percent of full-time, as defined in *Part III*, you are eligible to participate in the plan. You can then enroll in the plan by completing, signing, and returning an *Election Form* to the plan representative during the 30-day benefit election period that begins on the day of your schedule increase.

The benefit elections and salary reduction authorization you indicate on the *Election Form* will be effective the first day of the payroll period that coincides with or follows the day you meet the eligibility requirements for participating in the plan **and** return the completed *Election Form* to the plan representative.

If you do not complete, sign, and return an *Election Form* to the plan representative during the 30-day benefit election period that begins on the day of your change in hours to eligible status, you will be considered to have elected not to participate in FlexChoice for the remainder of the plan year and will have to wait until the following plan year before you have another opportunity to participate in the plan.

D. Participation Following Termination of Employment

If your participation in FlexChoice terminates because you cease to be an employee of Goshen College and during the same plan year you are rehired by Goshen College and again meet plan eligibility requirements, you may participate in FlexChoice as follows:

1. If you are rehired within 30 days following the date employment terminated, the benefit elections and salary reduction authorization in effect prior to termination will be reinstated for the remainder of the plan year under the same terms in effect prior to termination; or
2. If you are rehired more than 30 days following the date employment terminated, you may make new benefit elections and salary reduction authorization for the remainder of the plan year.

E. Unpaid Leave of Absence

If you take an unpaid leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or if you take any other approved unpaid leave of absence as allowed in the employer personnel policy in effect at the time of the leave, you may elect to continue your premium expense and/or medical expense reimbursement benefit elections during the leave or revoke the elections for the remainder of the coverage period as outlined in this section.

Continuation of Premium Expense and/or Medical Expense Reimbursement Benefit Elections

If you elect to continue your premium expense and/or medical expense reimbursement benefit elections during an unpaid leave of absence, Goshen College will maintain the benefits on the same conditions as would have been provided if you had been continuously working.

While on an unpaid leave of absence, you have the option to pay the premiums for your benefit election(s) in one or a combination of the following ways:

1. Payment of the required premiums during the leave on an after-tax basis on the same schedule as the premiums were paid when you were not on leave.
2. Catch-up payment of the required premiums through salary reduction on a pretax basis after you return from the leave.

When an unpaid leave of absence ends and you return to work, the salary reduction authorization in effect prior to the leave will resume for the remainder of the plan year under the same terms in effect prior to the leave unless you change your elections due to a change in status or other qualifying event. In this case, the rules in *Section G* apply.

If you fail to return to work when an unpaid leave of absence ends, Goshen College may recover from you its share of premiums paid during the period of unpaid leave, except when your entitled leave under the Family and Medical Leave Act of 1993 (FMLA) has been exhausted and you do not return to work due to:

1. The continuation, recurrence, or onset of a serious health condition that would entitle you to leave under FMLA; or
2. Other circumstances beyond your control, as defined under FMLA.

Revocation of Premium Expense and/or Medical Expense Reimbursement Benefit Elections

If you elect to revoke your premium expense and/or medical expense reimbursement benefit elections during an unpaid leave, plan benefits and salary reduction to pay the premiums for plan benefits will stop with the last day of the payroll period that coincides with or follows your last day of work. **Any medical expenses incurred during the unpaid leave will not be eligible for reimbursement.**

You may elect to reinstate your premium expense and/or medical expense reimbursement benefit elections on a prospective basis when the unpaid leave ends and you return to work as outlined below. However, you may not retroactively elect reimbursement benefits for medical expenses incurred during the period of revocation. You also may not retroactively elect premium expense benefits for the period of revocation.

The premium expense benefit election and salary reduction authorization in effect prior to your unpaid leave will be reinstated for the remainder of the plan year under the same terms in effect prior to the leave unless you change your

election due to a change in status or other qualifying event (in this case, the rules in *Section G* apply). However, the annual premium for group health plan coverage will be prorated to take into account the period of revocation.

You have the following options when reinstating your medical expense reimbursement benefit election and salary reduction authorization:

1. You may reinstate coverage on a reduced basis. The maximum annual benefit and corresponding annual premium in effect prior to the unpaid leave will be prorated to take into account the period of revocation. The same salary reduction authorization in effect prior to the unpaid leave will be resumed for the remaining months of the plan year; or
2. You may reinstate the original level of coverage. The maximum annual benefit and corresponding annual premium in effect prior to the unpaid leave will be continued and your salary reduction authorization will be increased for the remaining months of the plan year to make up the unpaid premiums from the period of revocation.

Revocation of Dependent Care Reimbursement Benefit Election

Your dependent care reimbursement benefit election and salary reduction authorization will automatically be revoked for the period of time you are on an unpaid leave. When the leave ends and you return to work, you may elect to reinstate the election. The dependent care reimbursement benefit election and salary reduction authorization in effect prior to your unpaid leave will be reinstated for the remainder of the plan year under the same terms in effect prior to the leave unless you change your election due to a change in status or other qualifying event (in this case the rules in *Section G* apply). However, the maximum annual benefit available and corresponding annual premium will be prorated to take into account the period of revocation.

F. Paid Leave of Absence

Continuation of Premium Expense and/or Medical Expense Reimbursement Benefit Elections

If you take a paid leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA), or if you take any other approved paid leave of absence as allowed in the employer personnel policy in effect at the time of the leave, your premium expense and/or medical expense reimbursement benefit elections and salary reduction authorization will automatically continue during the paid leave on the same basis as was in effect prior to the beginning of the paid leave, unless you change your elections due to a change in status or other qualifying event (in this case the rules in *Section G* apply).

Revocation of Dependent Care Reimbursement Benefit Election

Your dependent care reimbursement benefit election and salary reduction authorization will automatically be revoked for the period of time you are on a paid leave. When the leave ends and you return to work, you may elect to reinstate the election. The dependent care reimbursement benefit election and salary reduction authorization in effect prior to your leave will be reinstated for the remainder of the plan year under the same terms in effect prior to the leave unless you change your election due to a change in status or other qualifying event (in this case the rules in *Section G* apply). However, the maximum annual benefit available and corresponding annual premium will be prorated to take into account the period of revocation.

G. Irrevocability of Elections

Except as provided in this *Section G*, you are not permitted to revoke or change your benefit elections and salary reduction authorization for the duration of the plan year to which they relate. This means you may not make a mid-year revocation or change of your benefit election(s), maximum annual benefits, or salary reduction authorization except in the following situations:

Change in Status (applies to all benefits)

If you experience a change in status (as defined below), you may make a mid-year revocation or change of your benefit elections and salary reduction authorization, but only if:

1. The change in status:
 - a. Results in you or your dependent(s) gaining or losing eligibility for coverage under your or your dependent's employer-sponsored group health plan; or
 - b. Affects eligibility for dependent care expenses to be reimbursed on a pretax basis under Section 129 of the Code; **and**
2. The change or revocation is on account of and consistent with the change in status. The plan administrator (in its sole discretion) will determine whether a requested revocation or change is consistent with and attributable to a change in status.

Currently, federal law considers the following events to qualify as a change in status:

1. A change in your legal marital status (marriage, divorce, annulment, legal separation, or death of your spouse);

2. A change in the number of your dependents (birth, placement for adoption, or adoption of a child; or death of a dependent);
3. A change in employment status for you or your dependent(s) such as:
 - a. Commencement or termination of employment;
 - b. A strike or lockout;
 - c. Commencement or return from an unpaid leave of absence;
 - d. Changing from full-time to part-time or the reverse; and
 - e. A change in worksite.
4. Your dependent satisfies or ceases to satisfy dependent eligibility requirements for coverage (reaching a specified age, marriage, gain or loss of student status, etc.); or
5. A change in the place of residence for you or any of your dependents (when such change affects eligibility for coverage under a group health plan).

Judgments, Decrees, and Orders (does not apply to dependent care reimbursement benefit)

If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requires health or accident coverage to be provided for your dependent child, you may change your premium expense benefit election and salary reduction authorization to:

1. Pay the premium for group health plan coverage for the child on a pretax basis through salary reduction — if the judgment, decree, or order requires you to provide coverage; or
2. Cancel payment of the premium for group health plan coverage for the child on a pretax basis through salary reduction — if the judgment, decree, or order requires that your former spouse provide coverage under his or her plan **and** the coverage is actually provided for the child by your former spouse.

You may also make a corresponding change to your medical expense reimbursement benefit election and salary reduction authorization.

Medicare and Medicaid Entitlement (does not apply to dependent care reimbursement benefit)

You may change or revoke your premium expense benefit election and salary reduction authorization if you or any of your dependents who are enrolled in a group health plan become entitled to Medicare or Medicaid. A change or revocation is allowed to cancel payment of the premium for group health plan coverage on a pretax basis for the person becoming entitled to Medicare or Medicaid.

In addition, if you or any of your dependents who have been entitled to Medicare or Medicaid lose eligibility for such coverage and begin coverage under a group health plan, you may prospectively change your premium expense benefit election and salary reduction authorization to pay the premium for group health plan coverage for the person losing Medicare or Medicaid entitlement on a pretax basis through salary reduction.

You may also make a corresponding change to your medical expense reimbursement benefit election and salary reduction authorization.

Special Enrollment Rights (does not apply to reimbursement benefits)

If you or any of your dependents are entitled to special enrollment rights under a group health plan, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, you may change your premium expense benefit election and salary reduction authorization to pay the premium for group health plan coverage which corresponds with the special enrollment right on a pretax basis through salary reduction.

Continuation of Coverage Eligibility (does not apply to dependent care reimbursement benefit)

If your dependent becomes eligible for continuation of coverage under a group health plan and continues to qualify as your dependent (as defined in *Part II*), you may change your premium expense benefit election and salary reduction authorization to pay the premium for continuation of coverage for your dependent on a pretax basis through salary reduction.

You may also make a corresponding change to your medical expense reimbursement benefit election and salary reduction authorization.

Insignificant Change in Cost (does not apply to reimbursement benefits)

If the cost of coverage under a group health plan increases or decreases insignificantly, as determined by the plan administrator, your premium expense salary reduction authorization will automatically be increased or decreased on a prospective basis for the remainder of the plan year to reflect the change.

Significant Cost Increases (does not apply to medical expense reimbursement benefit)

If the cost of coverage under a group health plan increases significantly, as determined by the plan administrator, you may change your premium expense benefit election and salary reduction authorization to:

1. Increase your salary reduction authorization to pay the increased premium for the applicable group health plan on a pretax basis;
2. Cancel payment of the premium for coverage under the applicable group health plan on a pretax basis through salary reduction – if you cancel coverage under the plan – and, if you elect coverage on a prospective basis under another group health plan that provides similar coverage (if offered by the employer), pay the premium for the new coverage on a pretax basis through salary reduction; or
3. Cancel payment of the premium for coverage under the applicable group health plan on a pretax basis through salary reduction – if you cancel coverage under the plan and no other group health plan providing similar coverage is offered by the employer.

If the cost of coverage for dependent care services increases significantly, you may change your dependent care reimbursement benefit election and salary reduction authorization to:

1. Increase your dependent care reimbursement benefit election and salary reduction authorization to pay the increased fees for dependent care coverage on a pretax basis;
2. Change dependent care coverage to another dependent care provider providing similar coverage and make a corresponding change in your dependent care reimbursement benefit election and salary reduction authorization; or
3. Terminate dependent care coverage and revoke your dependent care reimbursement benefit election and salary reduction authorization, if no other dependent care provider options are available.

However, an election change **is not** permitted for a change in the cost of coverage by a dependent care provider that is a relative.

Significant Curtailment or Loss of Coverage (does not apply to medical expense reimbursement benefit)

If the employer eliminates a group health plan in the middle of a plan year which results in a loss of group health plan coverage, you may change your premium expense benefit election and salary reduction authorization to:

1. Cancel payment of the premium for the eliminated group health plan on a pretax basis through salary reduction and pay the premium for new coverage under another group health plan that provides similar coverage (if offered by the employer) on a pretax basis through salary reduction; or
2. Cancel payment of the premium for the eliminated group health plan on a pretax basis through salary reduction if no other group health plan providing similar coverage is offered by the employer.

If the benefits of a group health plan are significantly curtailed in the middle of a plan year, you may change your premium expense benefit election and salary reduction authorization to cancel payment of the premium for coverage under the applicable group health plan on a pretax basis through salary reduction – if you cancel coverage under the plan – and, if you elect coverage on a prospective basis under another group health plan that provides similar coverage (if offered by the employer), pay the premium for the new coverage on a pretax basis through salary reduction.

You may change your dependent care reimbursement benefit election and salary reduction authorization during a plan year if the dependent care coverage changes. Dependent care coverage changes include change in daycare provider and change in the necessary hours of dependent daycare.

Change in Coverage Under Other Employer Plan (does not apply to medical expense reimbursement benefit)

You may change your premium expense benefit election and salary reduction authorization when the change is on account of and corresponds with a change in coverage made under another employer group health plan (including a group health plan provided through your employer or the employer of your spouse or dependent child) if:

1. The other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under Section 125 of the Code; or
2. This plan permits participants to make an election for a plan year period of coverage that is different from the plan year period of coverage under the other cafeteria plan or qualified benefits plan.

You may decrease or revoke your dependent care reimbursement benefit election and salary reduction authorization during a plan year if you, your spouse, or your dependent have elected or received corresponding increased dependent care coverage under another employer plan. Likewise, you may also increase your dependent care reimbursement benefit election and salary reduction authorization if you, your spouse, or your dependent have elected or received corresponding decreased dependent care coverage under another employer plan.

Miscellaneous Information

If you are entitled to make a mid-year change or revocation of your benefit elections and/or salary reduction authorization under the terms of this *Section G*, you must contact the plan representative and complete the required *Change Form* during the 30-day benefit election period that immediately follows the qualifying event.

If you do not complete, sign, and return a *Change Form* to the plan representative during the 30-day benefit election period that follows a qualifying event, you will have to wait until the following plan year before you have another opportunity to change or revoke your benefit elections and/or salary reduction authorization.

Subject to the provisions of the underlying group health plan, a change in election to begin premium expense benefits for group health plan coverage for a newborn or newly-adopted dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to 30 days. All other changes in benefit elections and/or salary reduction authorization will be effective the first day of the payroll period that coincides with or follows the day you return the completed *Change Form* to the plan representative.

H. Election Modifications Required by the Plan Administrator

Under the Code, highly compensated and key employees are generally plan participants who are officers or shareholders of the company or highly paid. The plan administrator will notify you each plan year if you are considered to be a highly compensated or key employee.

If you are a highly compensated or key employee, the plan administrator may require you to limit the maximum annual benefits you elect under FlexChoice in order for the plan to meet all non-discrimination requirements required by Section 125 of the Code.

Part V, Reimbursement Accounts

Through FlexChoice, Goshen College will establish a separate reimbursement account for each reimbursement benefit — medical expense and dependent care — you elect to participate in during a plan year. These accounts provide you with an opportunity to be reimbursed for qualified out-of-pocket medical and dependent care expenses and pay the required premium for such benefits on a pretax basis through salary reduction.

If you elect to participate in both the medical expense and dependent care reimbursement benefits, two separate accounts will be established. The funds in the two accounts cannot be mixed. This means that if you are reimbursed for the annual benefit amount you elect for your Medical Expense Reimbursement Account before the end of the plan year, but have a balance remaining in your Dependent Care Reimbursement Account, you cannot use this balance to be reimbursed for medical expenses. Likewise, you cannot be reimbursed for dependent care expenses from the balance in your Medical Expense Reimbursement Account.

It is important to carefully estimate your annual unreimbursed qualified medical and dependent care expenses. The Code requires that you must forfeit any amounts in your reimbursement accounts that are not spent in a plan year. Balances remaining at the end of the plan year cannot be carried over to the next plan year.

The FlexChoice administrator will provide you with quarterly statements during the plan year that show your premium payments for reimbursement benefits, *Reimbursement Requests* processed, and your reimbursement account balance(s) as of the statement date. You will also be notified at least 30 days prior to the end of the plan year if a balance remains in either of your reimbursement accounts.

You may also view your past and current reimbursement account balance(s) and transactions online at any time. To view account information online, go to www.Everence.com and the “Access your accounts” area, then select “My Everence” to log in and choose the “FlexChoice” option. If this is the first time you are viewing account information online through “My Everence”, you will first need to register by following the instructions provided.

You may elect to be notified electronically when quarterly statements are available and when a *Reimbursement Request* is paid by check or direct deposit. You may then view the statement or reimbursement details online through the “FlexChoice” option of “My Everence”. If you choose this option, you will no longer receive paper copies of quarterly statements and direct deposit transactions (although they may be printed from “My Everence”). You must authorize electronic notifications through the “FlexChoice” option of “My Everence”.

A. Medical Expense Reimbursement Account

If you elect to participate in the medical expense reimbursement benefit, Goshen College will establish a Medical Expense Reimbursement Account in your name to keep a record of the amount of reimbursement you elect for a plan year, the premiums you pay for such benefits during the plan year, as well as the amount of reimbursements paid to you during the plan year. Your Medical Expense Reimbursement Account will be credited the first payroll period of the plan year with the annual benefit amount you elect for that plan year.

You will be reimbursed for qualified medical expenses from your Medical Expense Reimbursement Account as outlined in *Part VII*.

Qualified Medical Expenses

To be a qualified medical expense eligible for reimbursement, the expense:

1. Must be incurred by you or any of your dependents for medical care during the plan year for which an election is in force;
2. Must qualify as an expense incurred for medical care as defined by Section 213(d) of the Code. However, premiums for health insurance coverage and expenses for qualified long-term care services are not qualified medical expenses under this benefit;
3. Cannot be eligible for payment by a health plan or reimbursable by any other plan; and
4. Cannot be taken as an income tax deduction on your federal income tax return in any year.

Expenses are considered to be incurred on the date the service is provided, not when the service is billed or paid.

Qualified medical expenses include, but are not limited to the following:

1. Health plan deductible and coinsurance payments;
2. Health plan copayments;
3. Medical care not eligible for payment by a health plan;
4. Non-prescription drugs and medications prescribed by a physician to treat a specific medical condition*;
5. Vitamins and nutritional supplements prescribed by a physician to treat a specific medical condition**;
6. Dental care not eligible for payment by a dental plan;
7. Orthodontia not eligible for payment by a dental plan;
8. Vision care not eligible for payment by a vision plan, including contact lenses and solution;
9. Hearing care;
10. Transportation necessary to receive medical care;
11. Special communications equipment for the deaf;
12. Special education for the blind; and
13. Tuition at a special school for the handicapped.

*Effective Jan. 1, 2011, a non-prescription drug or medication (other than insulin) is a qualified medical expense only if you have a prescription from your physician or other health care professional. Prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and is issued by an individual who is legally authorized to issue a prescription in that state. All other non-prescription drugs and medications for which you do not have a prescription will no longer be eligible for reimbursement. The FlexChoice administrator shall have sole discretion to determine on a uniform and consistent basis whether a particular item is a non-prescription drug or medication and whether the requirement of a prescription has been met.

**A nutritional supplement or vitamin is a qualified medical expense only if you submit a letter or prescription from your physician to the FlexChoice administrator once each plan year indicating the name of the patient and the medical condition the nutritional supplement or vitamin is prescribed for.

The Internal Revenue Service has not issued a list of qualified medical expenses specific to Section 125 flexible benefits plans. However, IRS Publication 502 lists many of the expenses for medical care (as defined under Section 213(d) of the Code) that are considered qualified medical expenses under this plan. Please keep in mind that this is a guide only and is not an exact list of qualified medical expenses eligible for reimbursement under this plan. Publication 502 is available from the plan representative or can be ordered directly from the IRS by calling (800) 829-3676.

Maximum Annual Benefit

The maximum annual benefit you may elect to receive in the form of reimbursement from your Medical Expense Reimbursement Account for qualified medical expenses incurred in any plan year is \$5,000. The minimum annual benefit you may elect to receive in any plan year is \$60.

For any short plan year, the maximum and minimum annual benefit amounts will be prorated accordingly.

Annual Premium

The annual premium for benefits available through the medical expense reimbursement benefit in a plan year is equal to the annual benefit amount you elect for that plan year. Payment of the annual premium will be made over the course of the plan year through salary reduction each payroll period in an amount equal to the annual premium divided by the number of applicable payroll periods in the plan year.

B. Dependent Care Reimbursement Account

If you are an eligible employee and elect to participate in the dependent care reimbursement benefit, Goshen College will establish a Dependent Care Reimbursement Account in your name to keep a record of the amount of reimbursement you elect for the costs of qualified work-related child and dependent care, the premiums you pay for such benefits during the plan year, as well as the amount of reimbursements paid to you during the plan year.

You will be reimbursed for qualified dependent care expenses from your Dependent Care Reimbursement Account as outlined in *Part VII*.

To be an eligible employee, you must satisfy at least one of the following requirements:

1. Both you and your spouse are employed;
2. Your spouse is disabled;
3. Your spouse is a full-time student; or
4. You are single.

Qualified Dependent Care Expenses

To be a qualified dependent care expense eligible for reimbursement, the following criteria must be met:

1. The dependent care must be provided by eligible providers to a dependent who is a qualifying individual (see definition of dependent in *Part II*);
2. The dependent care expenses must be work-related (needed for you and your spouse to work or look for work); and
3. The expense must be incurred during the plan year for which an election is in force.

Eligible providers include the following:

1. An individual inside or outside your home;
2. An educational institution for preschool children (for older children, only expenses for non-educational care are eligible); and
3. A qualified daycare facility, if the care is for a dependent under age 13 or any other qualifying individual who regularly spends at least eight hours each day in your home.

Dependent care expenses are not eligible for reimbursement if payment is made to:

1. Your spouse;
2. Your child who is under age 19 at the end of the calendar year;
3. Your dependent for income tax purposes; or
4. A daycare facility caring for more than six persons that does not comply with all state or local requirements.

A more complete listing of qualified dependent care expenses is included in IRS Publication 503, which is available from the plan representative or can be ordered directly from the IRS by calling (800) 829-3676. This is a guide only.

To qualify as a pretax benefit, you must list on Form 2441 of your federal income tax return the name and taxpayer identification number of each provider of dependent care services during the calendar year for which you received a pretax reimbursement.

Maximum Annual Benefit

The maximum annual benefit you may elect to receive in the form of reimbursement from your Dependent Care Reimbursement Account for qualified dependent care expenses incurred in any *calendar year* may not exceed the least of the following amounts:

1. \$4,992 (if you are married filing a joint return or single filing as head of household) or \$2,496 (if you are married and filing separate tax returns);
2. Your earned income — if you are single at the end of the calendar year; or
3. The earned income of the lower paid spouse — if you are married at the end of the calendar year.

Special rules apply if your spouse is a student or is disabled. If your spouse is either a qualifying individual or a full-time student for at least five months during the calendar year, then for each month that your spouse is either a qualifying individual or a full-time student, his or her monthly earned income will be considered to be no less than:

1. \$250, if you have one qualifying individual for the year; or
2. \$500, if you have two or more qualifying individuals for the year.

Annual Premium

The annual premium for benefits available through the dependent care reimbursement benefit in a plan year is equal to the annual benefit amount you elect for that plan year. Payment of the annual premium will be made through salary reduction each payroll period in an amount equal to the annual premium divided by the number of applicable payroll periods in the plan year. The amount deducted from your paycheck will be credited to your Dependent Care Reimbursement Account each payroll period.

Dependent Care Tax Credit

When you receive pretax benefits through your Dependent Care Reimbursement Account, your ability to claim the Dependent Care Tax Credit on your personal federal income tax return is affected. Any pretax benefits received through your Dependent Care Reimbursement Account will reduce on a dollar-for-dollar basis the maximum amount of expense eligible under the Dependent Care Tax Credit.

Part VI, Premium Expense Benefit

Through the premium expense benefit of FlexChoice, you have the option to pay the required premiums for employer-provided group health plan coverage on a pretax basis through salary reduction or instead elect to receive your full salary in cash and pay the required premiums for group health plan coverage on an after-tax basis outside of FlexChoice.

If you elect to pay the premiums for group health plan coverage on a pretax basis through FlexChoice, Goshen College will establish a “notational” Premium Expense Account in your name to keep a record of the amount Goshen College has paid for the types and level of group health plan coverage you elect to participate in, as well as the premiums you pay for such benefits during the plan year. The various plan and coverage options are listed on the *Election Form*.

While the premiums for group health plan coverage are paid on a pretax basis through FlexChoice, the benefits are provided by each group health plan, not this plan. The type and amount of benefits available, eligibility requirements for participating in a group health plan, and other terms and conditions of coverage under each group health plan are set forth in that plan. All claims to receive benefits under a group health plan are subject to and governed by the terms and conditions of that group health plan.

You may not use the premium expense benefit of this plan to pay, on a pretax basis, the required premiums for:

1. A group health plan sponsored or provided by the employer of your dependent; or
2. Other insurance coverage not sponsored or provided by Goshen College.

Maximum Annual Benefit

The maximum annual amount of premiums for group health plan coverage you may elect to pay on a pretax basis through salary reduction in any plan year is the total amount of the required premium(s) for the types and level of group health plan coverage you elect for that plan year. The amount of your salary reduction each payroll period will be the annual aggregate amount of all required premiums for the plan year divided by the number of applicable payroll periods in that plan year.

Part VII, How To Request Reimbursement

A. Submitting a Reimbursement Request

To be reimbursed for qualified expenses from your Medical Expense Reimbursement Account or Dependent Care Reimbursement Account, you must complete a *Reimbursement Request* and submit it directly to the FlexChoice administrator at the address listed on the *Reimbursement Request* with the appropriate documentation attached. *Reimbursement Requests* may be obtained from the plan representative or the FlexChoice administrator.

It is your responsibility to make certain all expenses submitted for reimbursement from your Medical Expense Reimbursement Account or Dependent Care Reimbursement Account are qualified expenses eligible for

reimbursement. You are required to sign each *Reimbursement Request* to certify that the expenses submitted are qualified expenses.

You may submit a *Reimbursement Request* for qualified expenses incurred during a plan year at any time during the plan year or within the three-month runout period that follows the end of the plan year. *Reimbursement Requests* submitted after Sept. 30 of the plan year following the plan year in which the expenses are incurred are not eligible for reimbursement.

Expenses for services incurred before you begin participating in the plan or after your participation in the plan terminates are not eligible for reimbursement, except as allowed for dependent care expenses under *Part IX*.

Medical Expenses

When submitting a *Reimbursement Request* for qualified medical expenses, you must attach verifying documentation showing the unreimbursed portion of the medical expenses. Eligible documentation includes a copy of the original itemized bill, *Explanation of Benefits*, invoices, or receipts indicating the following information:

1. The person for whom the expense was incurred,
2. Date the expense was incurred,
3. Name of the service provider,
4. Nature of the expense incurred, and
5. Amount of the expense incurred.

The receipt for a non-prescription drug or medication, vitamins, and nutritional supplements must identify the purchased item, amount paid, and date of purchase.

The *Reimbursement Request* for a non-prescription drug or medication (other than insulin) purchased on or after Jan. 1, 2011, must include a copy of the prescription written by the physician or other health care professional which indicates the name of the non-prescription drug or medication, the name of the patient, and the medical condition the non-prescription drug or medication is prescribed for. The FlexChoice administrator shall have sole discretion to determine on a uniform and consistent basis whether a particular item is a non-prescription drug or medication and whether the requirement of a prescription has been met.

If you request reimbursement for nutritional supplements or vitamins, once a year you are required to submit to the FlexChoice administrator a letter or prescription written by your physician indicating the name of the patient and the medical condition the nutritional supplement or vitamin is prescribed for.

Expenses eligible for coverage under a health plan must be submitted first to the health plan. Any amounts not paid under the health plan will be indicated on the *Explanation of Benefits*. When you submit the *Reimbursement Request* to the FlexChoice administrator, a copy of the *Explanation of Benefits* must be attached to it (keep the original for your records).

You will be reimbursed from your Medical Expense Reimbursement Account the full amount of submitted qualified medical expenses, up to your total medical expense reimbursement annual benefit election, less any prior reimbursements received during the plan year.

Dependent Care Expenses

When submitting a *Reimbursement Request* for dependent care expenses, you need to attach a statement from the provider indicating the following information:

1. Dates of the service,
2. Name of the dependent receiving care,
3. Name and address of the provider, and
4. Amount of the dependent care expenses.

The statement must be signed by the provider to verify the information listed.

Once a year you will be asked to submit the taxpayer identification number of each dependent care service provider to the FlexChoice administrator.

You will be reimbursed for qualified dependent care expenses only to the extent there is a sufficient balance in your Dependent Care Reimbursement Account to cover submitted qualified expenses. Any unpaid amount will automatically be paid when additional premium payments through salary reduction are credited to your Dependent Care Reimbursement Account.

B. Payment Schedule

Reimbursement checks will be issued twice a month. The check for a *Reimbursement Request* received by the FlexChoice administrator by 5 p.m. on the first Friday of the month will be issued by the second Friday of the month; those received by 5 p.m. on the third Friday of the month will be issued by the fourth Friday of the month.

Instead of receiving paper checks, you may elect to have reimbursements deposited directly into your bank account. To sign up for direct deposit, you must complete the *Authorization to Receive, Change, or Cancel Direct Deposit* form which is available from the plan representative or the FlexChoice administrator. This form is also available online. Go to www.Everence.com and the "Access your accounts" area, then select "My Everence" to log in and choose the "FlexChoice" option. If this is the first time you are viewing account information online through "My Everence", you will first need to register by following the instructions provided.

When a *Reimbursement Request* is paid, you will receive a payment statement attached to the reimbursement check. If you elect direct deposit, a paper copy of the payment statement will be mailed to you unless you have also elected electronic notification. In this case, you will be notified electronically that the reimbursement has been paid through direct deposit and the transaction details may be viewed online through the "FlexChoice" option of "My Everence".

Please review the payment statement carefully so you understand how the expenses have been paid. The payment statement will list:

1. The total reimbursement requested;
2. The total amount not reimbursed by the plan;
3. The total amount reimbursed;
4. For whom the reimbursement was paid; and
5. A description of the care, service, or treatment given.

If a *Reimbursement Request* is not paid (in whole or in part), the payment statement will include specific information about the denial and the plan's appeals procedures, as outlined in *Part VIII*.

C. Year-end Reimbursement Account Balances

Any balance remaining in your Medical Expense Reimbursement Account or Dependent Care Reimbursement Account at the end of the plan year cannot be refunded or carried over to the next plan year. **The Code requires that you must forfeit any balances in your reimbursement accounts that are not spent in a plan year.**

D. Payment of Group Health Plan Premium(s)

When you pay the required premium(s) for group health plan coverage on a pretax basis through FlexChoice, you do not need to complete a *Reimbursement Request*. The amount of the required premium(s) will be paid automatically in the form of salary reduction each payroll period in an amount equal to the aggregate annual required premium(s) divided by the number of applicable payroll periods in the plan year.

Part VIII, When a Reimbursement Request is Denied

If a *Reimbursement Request* is denied because the FlexChoice administrator determines the expense is not a qualified expense eligible for reimbursement according to the terms of the plan, the FlexChoice administrator will notify you in writing. The notification will include the following information:

1. The specific reason for denial;
2. The plan provision on which the denial is based;
3. A description of any additional material or information required to complete the *Reimbursement Request* and an explanation of why the information is necessary; and
4. An explanation of the plan's appeals procedures, including time limitations.

If the reason for denial of a *Reimbursement Request* is unclear to you, please contact the FlexChoice administrator for clarification.

Appealing a Denied Reimbursement Request

If, after talking with the FlexChoice administrator, your question or concern is not addressed to your satisfaction, or if you do not agree with the denial, you may request a review by the plan administrator. To request review and reconsideration of a denied *Reimbursement Request*, you must submit a written appeal to the FlexChoice administrator

within 60 days following the day you receive written notification of the denial. You or your authorized representative may review pertinent documents and submit issues and comments to the plan administrator in writing.

The plan administrator has the power and final discretionary authority to interpret the provisions of the plan and will review the denied *Reimbursement Request*. A decision will be made by the plan administrator and notification provided to you within 60 days after the appeal is received. If special circumstances require an extension of time for processing, the decision will be made as soon as possible, but no later than 120 days after the written request for review is received. The decision will state the specific reasons for the decision and plan references on which it is based.

Part IX, Termination of Plan Participation

Your participation in FlexChoice or a specific benefit of FlexChoice, if applicable, will end on the first of the following events:

1. The last day of the month in which your schedule is changed so you do not regularly work at least 50 percent of full-time (as defined in *Part III*) as an active employee performing the normal duties of your job or otherwise no longer meet the eligibility requirements for participating in this plan;
2. The last day of the month in which your employment with Goshen College terminates;
3. The day you revoke your premium expense, medical expense reimbursement, and/or dependent care reimbursement benefit election(s) and salary reduction authorization due to and consistent with a change in status or other qualifying event (see *Part IV, Section G*);
4. The last day of the plan year for which you have elected to participate in the reimbursement benefit(s) of this plan (unless during the annual benefit election period you elect to participate in a new plan year); or
5. The day Goshen College discontinues the plan for everyone.

Payment of the required premiums for your benefit elections through salary reduction will automatically terminate with your last paycheck as an eligible employee or plan participant.

After your participation in the plan terminates, you may continue to submit *Reimbursement Requests* for qualified dependent care and medical expenses during the remainder of the plan year or within the three-month runout period that follows the end of the plan year in which the expenses are incurred with the following restrictions:

1. Qualified dependent care expenses incurred any time during the plan year, including the period of time after your participation in the plan terminates, will be reimbursed as long as a balance remains in your Dependent Care Reimbursement Account.
2. Qualified medical expenses incurred prior to the date your participation in the plan terminates will be reimbursed as long as a balance remains in your Medical Expense Reimbursement Account. Medical expenses incurred after the date your participation in the plan terminates are not eligible for reimbursement, unless you elect continuation of coverage as provided in *Part X*.

If your participation in the plan terminates because you stop working for Goshen College and within the same plan year you are rehired by Goshen College and again become eligible to participate in the plan, you may re-enroll in the plan as outlined in *Part IV, Section D*.

Part X, Continuation of Coverage

You and your dependents have the opportunity to continue participating in the medical expense reimbursement benefit of this plan on an after-tax basis for the remainder of the plan year if:

1. Participation in the plan terminates as a result of a qualifying event; and
2. Your Medical Expense Reimbursement Account has a positive balance at the time of the qualifying event.

Participation will cease at the end of the plan year in which the qualifying event occurs and cannot be continued in the following plan year.

You have the right to choose continuation of coverage under this plan if you are no longer eligible to participate in the plan because of either of the following qualifying events:

1. Reduction in your hours of employment with the employer; or
2. Termination of your employment with the employer (for reasons other than gross misconduct on your part).

Your dependents have the right to choose continuation of coverage if they are no longer eligible for plan benefits because of any of the following qualifying events:

1. Your death;
2. Reduction in your hours of employment with the employer;
3. Termination of your employment with the employer (other than by reason of gross misconduct);
4. You and your spouse divorce or legally separate;
5. You become entitled to Medicare benefits; or
6. For your dependent child only, your child ceases to qualify as a dependent according to the terms of the plan.

The required premium for continuation of coverage for the medical expense reimbursement benefit is equal to the benefit amount elected, plus a two percent surcharge for administrative expenses.

Check with your plan representative for more information about continuation of coverage.

Part XI, Provision of Protected Health Information to Plan Sponsor

A. Permitted and Required Uses and Disclosure of Protected Health Information

Subject to obtaining written certification pursuant to *Section C* of this *Part XI*, the plan may disclose protected health information, including electronic protected health information, to the plan sponsor, provided the plan sponsor does not use or disclose such protected health information except for the following purposes:

1. Performing plan administrative functions which the plan sponsor performs for the plan; or
2. Modifying, amending, or terminating the plan.

Notwithstanding the provisions of this plan to the contrary, in no event shall the plan sponsor be permitted to use or disclose protected health information or electronic protected health information in a manner that is inconsistent with 45 CFR §164.504(f).

B. Conditions of Disclosure

Protected Health Information

The plan shall not disclose protected health information to the plan sponsor unless the plan sponsor agrees to:

1. Not use or further disclose the protected health information other than as permitted or required by the plan or as required by law.
2. Ensure that any agents, including a subcontractor to whom it provides protected health information received from the plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to protected health information.
3. Not use or disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
4. Report to the plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available to a plan participant who requests access, the plan participant's protected health information in accordance with 45 CFR §164.524.
6. Make available to a plan participant who requests an amendment, the participant's protected health information and incorporate any amendments to the plan participant's protected health information in accordance with 45 CFR §164.526.
7. Make available to a plan participant who requests an accounting of disclosures of the plan participant's protected health information, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
8. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the plan available to the Secretary of Health and Human Services for purposes of determining compliance by the plan with 45 CFR §164.504(f).
9. If feasible, return or destroy all protected health information received from the plan that the 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 feasible.
10. Ensure that the adequate separation between the plan and the plan sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied.

Electronic Protected Health Information

The plan sponsor will not create, receive, maintain, or transmit any electronic protected health information on behalf of the plan unless the plan sponsor:

1. Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan.
2. Ensures that the adequate separation between the plan and the plan sponsor (i.e., the firewall), required by 45 CFR §164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
3. Ensures that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect such information.
4. Reports to the plan any security incident with respect to electronic protected health information of which it becomes aware.

C. Certification of Plan Sponsor

The plan shall disclose protected health information to the plan sponsor only upon the receipt of a Certification by the plan sponsor that the plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the plan sponsor agrees to the conditions of disclosure set forth in *Section B* of this *Part XI*.

D. Permitted Uses and Disclosure of Summary Health Information

The plan may disclose summary health information to the plan sponsor, provided such summary health information is only used by the plan sponsor for the purpose of modifying, amending, or terminating the plan.

E. Adequate Separation Between the Plan and the Plan Sponsor

The plan sponsor shall only allow the following employees of Goshen College to have access to protected health information:

1. Vice President for Finance, Goshen College;
2. Director of Human Resources, Goshen College; and
3. Administrative Assistant for Human Resources, Goshen College.

Such employees shall only have access to and use such protected health information to the extent necessary to perform the administrative functions that the plan sponsor performs for the plan. In the event that any such employees do not comply with the provisions of this *Part XI*, the employee shall be subject to disciplinary action by the plan sponsor for non-compliance pursuant to the plan sponsor's employee discipline and termination procedures.

The plan sponsor will ensure that the provisions of this *Section E* are supported by reasonable and appropriate security measures to the extent the employees designated in this *Section E* create, receive, maintain, or transmit electronic protected health information on behalf of the plan.

F. Definitions

For purposes of this *Part XI*, the following terms shall have the meaning set forth below unless otherwise provided by the plan:

Electronic protected health information — Protected health information that is transmitted by or maintained in any electronic media.

Plan sponsor — The plan sponsor of the plan is Goshen College.

Protected health information — Information that is created or received by the plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Protected health information includes information of persons living or deceased.

The following components of a member's information also are considered protected health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers,

including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary health information — Information that may be individually identifiable health information, and: a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 45 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.

Part XII, Administration of the Plan

A. Plan Administrator

Goshen College is the plan administrator of this plan and as such shall administer this plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this plan that the plan administrator shall have maximum legal discretionary authority to construe and interpret eligibility for benefits, decide disputes that may arise relative to a plan participant's rights, and decide questions of plan interpretation and those of fact relating to the plan. The decisions of the plan administrator will be final and binding on all interested parties.

The duties of the plan administrator include the following:

1. Requiring any plan participant to furnish such information as it may reasonably request for the purpose of the proper administration of the plan as a condition to receiving any benefit under the plan;
2. Keeping and maintaining plan documents, accounts showing the fiscal transactions of the plan, and all other records pertaining to the plan;
3. Ratifying or establishing practices and procedures relevant to the plan;
4. Designing plan provisions and implementing the amendment or termination of the plan;
5. Supplying plan participants with plan information (such as this summary plan description);
6. Administering the plan in accordance with its terms and conditions;
7. Interpreting all provisions of the plan and remedying ambiguities, inconsistencies, errors, or omissions;
8. Reporting to the FlexChoice administrator any change in the enrollment status of a plan participant within 30 days following an employment or special enrollment event that affects the employee's eligibility to participate in the plan. Such events include, but are not limited to commencement or termination of employment (voluntary or involuntary), death of an employee, increase or decrease in an employee's hours of employment, commencement or termination of a leave (including FMLA leave), etc.;
9. Reporting the annual benefit elected by each employee participating in the medical expense and/or dependent care reimbursement benefit(s) to the FlexChoice administrator upon enrollment and prior to the beginning of each plan year;
10. Reporting any mid-year change in a plan participant's medical expense and/or dependent care reimbursement benefit election(s) to the FlexChoice administrator within 30 days following the change;
11. Hearing and deciding all questions and appeals concerning the plan (including appeals of denied *Reimbursement Requests*) and the eligibility of any individual to participate in the plan;
12. Maintaining funds for the plan that are sufficient at all times for payment of plan benefits;
13. Filing all reports, tax returns, and forms, as may be required by any applicable law;
14. Securing legal review of plan documents from the plan's legal counsel, as necessary and appropriate;
15. Securing all necessary and appropriate legal determinations relating to the implementation and administration of the plan;
16. Initiating any action legally required in the event the plan becomes discriminatory;
17. Contracting with third party providers (including a FlexChoice administrator) to provide services deemed appropriate under the plan and monitoring their performance; and
18. Exercising all other functions not specifically delegated to others by the terms of the plan, as may be necessary for the operation of the plan.

B. FlexChoice Administrator

The FlexChoice administrator shall be appointed by the plan administrator and shall have the authority and responsibility to provide administrative services to the plan in connection with the operation of the plan. Everence Insurance Company is under contract with the plan as FlexChoice administrator and as such shall perform the duties outlined in the *Administrative Services Agreement* between the plan and Everence Insurance Company. These duties include:

1. Enrolling eligible employees who have elected to participate in the reimbursement benefit(s) of the plan, upon timely notice by the plan administrator;
2. Disenrolling plan participants who terminate participation in the medical expense and/or dependent care reimbursement benefit(s) of the plan or are no longer eligible to participate in the medical expense and/or dependent care reimbursement benefit(s) of the plan, upon timely notice by the plan administrator;
3. Providing a *Reimbursement Request* packet to each employee electing to participate in the medical expense and/or dependent care reimbursement benefit(s) of the plan, upon enrollment and at the beginning of each plan year;
4. Providing a verification letter to each employee electing to participate in the medical expense and/or dependent care reimbursement benefit(s) of the plan, upon enrollment and at the beginning of each plan year.
5. Interpreting the plan's provisions pertaining to payment of *Reimbursement Requests* submitted to the FlexChoice administrator;
6. Evaluating and processing *Reimbursement Requests* submitted and determining if expenses are eligible for reimbursement according to the terms of the plan;
7. Determining the amount, type, and form of reimbursement benefits that shall be payable to any person in accordance with the provisions of the plan;
8. Issuing reimbursement checks for qualified medical and dependent care expenses and providing a statement of the amount of reimbursement to plan participants;
9. Providing quarterly and year-end statements of medical expense and/or dependent care reimbursement account balance(s) to each plan participant enrolled in the medical expense and/or dependent care reimbursement benefit(s) of the plan.
10. Maintaining individual records to ensure that reimbursement payments for qualified dependent care expenses do not exceed a plan participant's dependent care reimbursement account balance;
11. Maintaining individual records to ensure that reimbursement payments for qualified medical expenses do not exceed a plan participant's annual benefit election;
12. Maintaining current plan data;
13. Providing and/or certifying requested information necessary for filing reports, tax returns, and forms, as may be required under any applicable law; and
14. Performing all other responsibilities as delegated by the plan administrator.

C. Delegation of Responsibilities

The plan administrator and the FlexChoice administrator may delegate their responsibilities to other persons or entities. When responsibilities are delegated between the above parties, notice of such delegation must be given to the other party. This requirement does not apply when responsibilities are delegated within any of the above – when said responsibilities are given to employees of the employer or the FlexChoice administrator.

D. Employment of Advisors

The plan administrator, any person to whom it may delegate any duty, responsibility, or power in connection with administering this plan (including the FlexChoice administrator), and the employer and the officers, directors, and employees thereof, shall be entitled to rely conclusively upon, and shall be fully protected in any action taken or suffered by them in good faith in reliance on any actuary, attorney, accountant, broker, consultants, or other specialist selected to provide assistance and/or advice concerning their responsibilities under the plan.

The plan administrator, persons to whom duty, responsibility, or power in connection with administering the plan has been delegated (including the FlexChoice administrator) and the employer and the officers or directors thereof, shall not be liable for any neglect, omission, or wrongdoing of an advisor.

E. Funding the Plan

This plan is a self-funded plan and the employer assumes the sole responsibility for funding the plan. Funding of the plan is derived solely from the general assets of the employer. Reimbursement benefits are paid directly from the plan through the FlexChoice administrator.

F. Expenses

All reasonable costs and expenses incurred in the implementation and administration of the plan, including but not limited to FlexChoice administration costs and fees, fees for advisors and bonding expenses, shall be paid by the employer.

G. Indemnification

The employer shall indemnify and hold harmless all employees of the employer, whether or not fiduciaries, from any and all liability, loss, or cost such employees may incur in the exercise of their duties and powers (or their failure to do so) under the plan, except as such liabilities, losses, or costs result from:

1. Their own gross negligence or willful misconduct; or
2. Any settlement of an action, suit, or proceeding without the employer's prior approval.

The employer shall also assume the defense of, or reimburse the expenses reasonably incurred in the defense of, as it may choose, any and all actions, suits, or proceedings arising under the plan and brought and advanced by any person, other than the employer, against such employee. However, this indemnification shall not act to relieve any such individual from a responsibility or liability for any fiduciary responsibility, obligation, or duty.

In addition, if a plan participant receives benefits under this plan on a tax-free basis and such benefits do not qualify for tax-free treatment under the Code, the plan participant shall indemnify and reimburse the employer for any liability the employer may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such benefits.

H. Forfeited Benefit Payments

Any benefit payable under this plan shall be forfeited if the plan administrator, after a reasonable effort, is unable to locate the plan participant to whom payment is due on a *Reimbursement Request* timely filed with the FlexChoice administrator. However, any such forfeited reimbursement payment shall be reinstated if claim is made for the payment by the individual, his or her estate, or other legal representative within the applicable time period for submitting a *Reimbursement Request*, described in *Part VII*.

Any reimbursement benefit payment that is unclaimed (uncashed benefit check) by the close of the plan year following the plan year in which the medical or dependent care expense was incurred shall be forfeited.

I. Right of Recovery

If reimbursement benefits are incorrectly paid to a plan participant, the FlexChoice administrator may recover such payment from the plan participant or subtract the overpayment from reimbursement benefits paid to the plan participant in the future.

Part XIII, Other Important Points

A. No Contract of Employment

The plan does not constitute a contract of employment between any employee and the employer. The employer's rights with regard to disciplinary action and termination of any employee, if necessary, are in no manner changed by participation in this plan or any provision of it.

B. Periodic Information Requests

In order to keep plan information up-to-date, the plan administrator or the FlexChoice administrator may request basic information about you or your dependent(s) that is required for payment of plan benefits according to plan provisions.

Each plan participant shall also furnish the plan administrator in the form prescribed by it and at its request such personal data, consents, authorizations to obtain information, or other information as the plan administrator deems necessary or desirable for the proper administration of the plan.

C. Incapacity

If the FlexChoice administrator determines that a plan participant cannot give a valid release for payment of reimbursement benefits, the FlexChoice administrator may, at its discretion, pay the individual who has assumed responsibility for the plan participant's financial affairs.

Any payment made by the FlexChoice administrator in accordance with this provision shall fully satisfy its liability for payment.

D. Non-assignment of Benefits

The benefits provided by the medical expense and dependent care reimbursement benefits of this plan are intended to reimburse plan participants for qualified medical and dependent care expenses. Therefore, a plan participant may not assign any of the benefits to which he or she may be entitled under the plan to any person or organization.

The plan is not liable for or subject to any debts of a plan participant entitled to benefits under this plan.

E. Coordination of Benefits under Medical Expense Reimbursement Benefit

The medical expense reimbursement benefit of this plan is intended to reimburse plan participants for qualified out-of-pocket medical expenses. Accordingly, it shall not be considered a group health plan for coordination-of-benefit purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

F. Misrepresentation

If an employee intentionally misrepresents a material fact, either verbally or in writing, or commits fraud and because of that intentional misrepresentation or fraud, coverage is given to the employee when he or she would otherwise not be eligible for coverage, the plan has the right to rescind coverage from the date it became effective and has the right to pursue recovery of any benefits received. At least 30 days advance notice will be provided before plan coverage is rescinded.

Likewise, if a plan participant knowingly makes a statement, either verbally or in writing, which is not true and because of that statement, a *Reimbursement Request* that would otherwise not be eligible for payment is paid, the plan has the right to pursue recovery of benefits received by the plan participant as a result of the *Reimbursement Request*.

G. Clerical Error/Misstatements

Clerical error in keeping records pertaining to plan coverage or delays in making entries shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment will be made upon discovery of such error or delay.

If any facts relevant to the existence of or amount of coverage have been misstated, the true facts will determine whether or not, and how much coverage is in force.

In addition, any clerical error or delay by the employer, the plan administrator, or an agent of the plan administrator in enrolling an individual as required by the terms of the plan will not invalidate coverage for which an individual would otherwise be eligible.

H. Enforceability

The plan (as described in this summary plan description and related documents which together constitute the plan), is maintained for the exclusive benefit of the employees of Goshen College. As a plan participant, your rights to its coverage and any particular benefit that it provides are legally enforceable.

I. No Guarantee of Tax Consequences

Neither the plan administrator nor the FlexChoice administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a plan participant will be excludable from the plan participant's gross income for federal or state income tax purposes.

It is the responsibility of each plan participant to determine whether benefits provided under this plan are excludable from the plan participant's gross income for income tax purposes and to notify the plan administrator if the plan participant has any reason to believe plan benefits are not so excludable.

J. Nondiscrimination

It is intended that this plan meet all nondiscrimination requirements to the extent required by Section 125 of the Code.

K. Code Compliance

It is intended that this plan meet all applicable requirements of the Code and all regulations issued thereunder. This plan shall be construed, operated, and administered accordingly. In the event of any conflict between any part, clause, or

provision of this plan and the Code, the provisions of the Code shall be deemed controlling. Any conflicting part, clause, or provision of this plan shall be deemed superseded to the extent of the conflict.

L. Governing Law

To the extent not preempted by the Code or other federal law, this plan shall be construed, enforced, and administered according to the laws of the state of Indiana.

M. Privacy

In administering plan benefits, the plan, the plan sponsor, the plan administrator, and the FlexChoice administrator will comply with all applicable privacy, access, and security statutes, rules, and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations on privacy and confidentiality of protected health information, outlined in 45 CFR §160 and §164, Subparts A and E, and security of electronic protected health information, outlined in 45 CFR §160 and §164, Subparts A, C, and D.

N. Amendment of the Plan

The plan sponsor reserves the right to amend the plan at any time without prior notice to employees. Any amendments to the plan will be in writing, based solely on the decision of the plan sponsor, and made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action. Properly executed amendments shall be delivered to the plan and the FlexChoice administrator. Plan participants will be notified of any amendment to the plan, in writing by the plan administrator.

If the plan is amended, it will not affect any benefit to which a plan participant was entitled before the effective date of the amendment.

Any approved amendments to the Goshen College FlexChoice Account Plan are incorporated into and become part of this summary plan description.

O. Termination of the Plan

The plan sponsor intends to maintain this plan indefinitely; however, it reserves the right to terminate the plan at any time, either in whole or in part, by an instrument properly executed and delivered to the plan and the FlexChoice administrator. Any such termination shall be in writing and made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action. Plan participants will be notified of any termination of the plan, in writing, by the plan administrator.

In the event the plan is terminated altogether, it will not affect any benefit to which a plan participant was entitled before the effective date of termination. Plan liability for payment of benefits shall be limited to payment of those qualified expenses incurred as of the date the plan is terminated.

Plan participants may submit *Reimbursement Requests* for qualified medical and dependent care expenses incurred prior to the effective date of the plan's termination to the FlexChoice administrator within the three-month runout period that immediately follows the date the plan is terminated.

Neither the plan, the plan sponsor, the plan administrator, nor the employer shall have any liability for expenses:

1. Incurred after the effective date of the plan's termination; or
2. Incurred prior to the effective date of the plan's termination but submitted to the plan more than three months after the effective date of the plan's termination.

Upon termination of the plan and after the payment or provision for payment of benefits to each plan participant to whom benefits are payable on the date of termination and otherwise permitted in accordance with plan terms, all remaining assets held with respect to the plan shall revert to the employer.

P. Role of Everence Insurance Company

Everence Insurance Company is under contract with the plan as administrator of enrollment and benefit payment functions of the plan. Everence Insurance Company does not guarantee the payment of any benefits under this plan.

Part XIV, Miscellaneous Plan Information

Name of the Plan:

Goshen College FlexChoice Account Plan

Type of Benefit Plan:

Section 125 Flexible Benefits Plan

Plan Sponsor:

Goshen College
1700 S. Main Street
Goshen, IN 46526
(574) 535-7000

Plan Administrator:

Goshen College
1700 S. Main Street
Goshen, IN 46526
(574) 535-7000

FlexChoice Administrator:

Everence Insurance Company
P.O. Box 483
Goshen, IN 46527
(574) 533-9511 or (800) 348-7468

Type of Plan Administrator:

Contract Administrator

Agent for Service of Legal Process:

Plan Administrator

Plan Number:

525

Plan Representative:

Vickie Miller

FEIN:

35-2158366

Plan Year:

July 1 – June 30

Plan Effective Date:

Jan. 1, 1989

Amended Plan Effective Date:

July 1, 2011

Appendix A

Benefits

The benefits listed below are a description of the benefits to be provided under the Goshen College FlexChoice Account Plan.

Premium Expense Benefit

Group Health Plans

Major Medical Health Plan:

- Mennonite Educators Benefit Plan

Dental Plan:

- Health Resources, Inc., Dental Health Options 6B-100 Plan

Vision Plan:

- Vision Service Plan B
- Vision Service Plan C

Supplemental Cancer Insurance Plan:

- Cancer Plus 30 Plan (not available for new enrollment)
- Aflac

Supplemental Accident Plan:

- Aflac

Specified Health Plan:

- Aflac

The insurance contract or policy underlying each group health plan shall govern the actual benefits to be provided under that plan. The premium for each group health plan will be paid by the employee on a pretax basis through salary reduction.

Reimbursement Benefits

Medical Expense Reimbursement

FlexChoice offers medical expense reimbursement benefits through a Medical Expense Reimbursement Account. An eligible employee electing to participate in the medical expense reimbursement benefit may elect to receive a maximum of \$5,000 in reimbursement for qualified medical expenses in any plan year from his or her Medical Expense Reimbursement Account. The minimum annual benefit an eligible employee may elect to receive in reimbursement in any plan year from his or her Medical Expense Reimbursement Account is \$60. These amounts will be prorated for a partial year's participation.

The premium for the medical expense reimbursement benefit will be paid by the employee on a pretax basis through salary reduction.

Dependent Care Reimbursement

FlexChoice offers dependent care reimbursement benefits through a Dependent Care Reimbursement Account. An eligible employee electing to participate in the dependent care reimbursement benefit may elect to receive the least of the following amounts in reimbursement for qualified dependent care expenses in any *calendar year* from his or her Dependent Care Expense Reimbursement Account:

- \$4,992 (if married and filing a joint tax return or single and filing as head of household) or \$2,496 (if married and filing separate tax returns)
- The employee's earned income (if single at the end of the calendar year)
- The earned income of the lower paid spouse (if married at the end of the calendar year)

The premium for the dependent care reimbursement benefit will be paid by the employee on a pretax basis through salary reduction.