ORAL ROBERTS UNIVERSITY

FLEXIBLE BENEFITS PLAN SUMMARY

Effective January 1, 2014

Flexible Benefits Plan
Summary

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INTRODUCTION

Oral Roberts University has established the Flexible Benefits Plan ("Plan"). The Plan is an opportunity for you to use pre-tax dollars to pay your share of the cost for certain of your employee benefits.

This document (including any appendix or other document incorporated by reference) is the Plan's "summary plan description" within the meaning of ERISA (the "Summary"). This Summary includes many of the Plan's important rules about Plan benefits. However, this Summary does not contain every detail of the Plan or all of its specific terms. You may read or request a copy of the official Plan and Benefits Program documents to learn about any additional terms, conditions and limitations that may apply. You may contact the Plan Administrator for this information.

GENERAL INFORMATION ABOUT THE PLAN

Purpose of the Plan

The purpose of the Plan is to allow you to choose to participate in one or more of the Plan's Benefits Program(s), and to enable you to pay for your participation in such program(s) with pre-tax dollars - having less effect on your take-home pay.

The Plan includes a pre-tax contribution feature that allows you to pay with pre-tax dollars the cost for your participation in the following Benefits Program(s):

- Medical Insurance Program
- Dental Insurance Program
- Health Care Reimbursement Program, and
- Dependent Care Assistance Program

Who Is Eligible

You are an Eligible Employee if you are a:

- regular Oral Roberts University faculty member who is considered "full time" as defined in the faculty contract, or
- regular Oral Roberts University full-time non-faculty staff employee. For this purpose, "full-time" means you work at least 30 hours per week, or
- regular University Broadcasting, Inc. full-time employee. For this purpose, "full-time" means you work at least 30 hours per week.

As an Eligible Employee, you may enroll for benefits under the Plan effective as of your "eligibility date." Your eligibility date for the Medical Insurance Program and the Dental Insurance Program is described in the documents governing those programs. If you are an Oral Roberts University faculty member who is an Eligible Employee, your eligibility date for the Health Care Reimbursement Program and the Dependent Care Assistance Program is the effective date of your full-time faculty contract period. For all other Eligible Employees, your eligibility date for the Health Care Reimbursement Program and the Dependent Care Assistance Program is the first day of the calendar month following your date of hire.

Please note that the eligibility provisions above are further subject to the terms of each applicable Benefits Program. For example, the definition of "full-time" for purposes of the Dental Insurance Program requires that you work at least 40 hours per week. You should review the Benefits Description for each Benefits Program to learn of any additional eligibility and enrollment restrictions. If you have a question about your eligibility, contact the Plan Administrator.

Important Eligibility Exceptions: You may not participate in the Plan if you are self-employed or treated as such for Federal income tax purposes. If you are considered a highly compensated employee under IRS rules, you are not eligible for Dependent Care Reimbursement Benefits.

Participation and Enrollment

To begin participation on your eligibility date described above, you must complete and submit the enrollment form within 30 days after your date of hire. You will also have the opportunity during the group open enrollment period each fall to make a new or changed election for benefits effective January 1 for the following coverage period, subject to any further restrictions under each Benefits Program.

The "coverage period" for the Plan is generally the calendar year. However, your coverage period may be shorter when you are first eligible or if you lose eligibility during a coverage period.

If you fail to make an election during your initial enrollment period you will not be enrolled in a Benefits Program. During annual enrollment, you must make a new election each year for Health Care Reimbursement Benefits and Dependent Care Reimbursement Benefits. All other Benefits Program elections remain in effect from one year to the next (at the new Benefits Program cost, if applicable) unless you make an election change.

Please note that the ability to enroll or make changes in your enrollment elections is further subject to the terms of each applicable benefits program. You should review the Benefits Description for each benefits program to learn of any additional enrollment and change restrictions.

Termination of Participation

Your participation in the Plan ends on the earlier of the date the Plan terminates or the date you are no longer eligible for participation in any Benefits Program. The documents governing each Benefits Program tell when you are no longer eligible for participation in such program. See the **COBRA Continuation Coverage** heading under the **Certain Legal Rights** section of this Summary for a discussion of any continuation of coverage rights that may apply.

Rehired Employees

If your employment with a Participating Employer ends and you are rehired within 30 days of your termination and during the same coverage period, your monthly contributions and levels of coverage will

be reinstated as if you never left employment, unless you have experienced an Election Change Event (discussed under the **Changing Your Election During the Coverage Period** section below). However, if you are rehired during a coverage period after being gone for more than 30 days, you may make new elections as a new employee for the remainder of the applicable coverage period. Furthermore, if you are rehired after the beginning of a new coverage period, then you may make new enrollment elections in the same manner as a new employee.

Leaves of Absence

If you take an approved leave of absence you may continue your coverage under a Benefits Program in accordance with the terms and conditions of the documents governing each such program and your Participating Employer's leave of absence policies. Special rules may apply to leaves that qualify under the Family and Medical Leave Act. See the **Coverage During Family and Medical Leave** heading under the **Certain Legal Rights** section of this Summary for rules that may apply. In addition, for an approved leave of absence that is a military leave, special rules may apply under the Uniformed Services Employment and Reemployment Rights Act. See the **Continuation of Coverage for Military Leave** heading under the **Certain Legal Rights** section of this Summary for rules that may apply.

Social Security Benefits

Participation in the Plan may slightly reduce your Social Security benefits because receiving tax-free benefits under the Plan reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

Changing Your Election During the Coverage Period

Generally, you cannot change the elections you have made for a coverage period. You may change your elections only during the annual enrollment period, and then, only for the next coverage period.

There is an important exception to this general rule: You may change your elections during a coverage period if you experience an Election Change Event. Any election changes made must be consistent with your Election Change Event. The rules and conditions that apply to Election Change Events are generally described in Appendix A to this Summary – Election Change Rules (attached). However, you should contact the Plan Administrator with questions about whether you have experienced an Election Change Event or to learn more about the types of election changes you may make in relation to such an event.

If an Election Change Event occurs, you generally must complete and deliver to the Plan Administrator your new election form within 30 days after the date of the change event as required by the Benefits Programs.

With respect to the Health Care Reimbursement Program, you may **not** make a change in your benefit election as the result of an Election Change Event.

Note: The Plan Administrator may modify your election(s) downward during the calendar year if you are a "key employee" or "highly compensated individual" (as defined by the Code), if it is necessary to comply with Federal law or to prevent the Plan from becoming discriminatory within the meaning of the Federal income tax law.

PARTICIPANT CONTRIBUTIONS

You have the opportunity to elect to pay for the cost of your participation in the Benefits Programs (listed above) under the Plan through salary reduction by completing an election form. This means that the share of the premiums you pay will be with pre-tax dollars, which generally saves you Social Security and income taxes on the amount of your salary reduction. The Employer will tell you what your share of the cost is for each coverage period.

How Contributions Are Made

When you complete the election form, you elect to pay for certain benefits through pre-tax salary reduction. When you pay with pre-tax dollars, the cost of your coverage elections will be paid with the portion of gross income that you have elected to forego through salary reduction.

Changes in Benefits Program Cost

If your share of a Benefits Program cost changes (increases or decreases) during the coverage period in an amount that the Plan Administrator determines is insignificant, your contribution election amount will automatically adjust to reflect the change in cost. For a discussion of allowable election changes if the Plan Administrator determines that cost change is significant, see Appendix A to this Summary – Election Change Rules (attached).

HEALTH CARE REIMBURSEMENT BENEFITS

As an Eligible Employee, you may be eligible to elect to receive tax-favored reimbursement for some or all of your unreimbursed eligible health care expenses under the Health Care Reimbursement Program.

Under the Health Care Reimbursement Program, you may elect a specific level of health care reimbursement benefits, paying for coverage through salary reduction in lieu of a corresponding amount of current pay. This arrangement helps you because the level of coverage you elect is generally nontaxable and you may save Social Security and income taxes on the amount of the contributions you make.

Health Care Reimbursement Account

If you elect benefits under the Health Care Reimbursement Program, an unfunded recordkeeping account ("Health Care Reimbursement Account") will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the contributions you make for such benefits during the coverage period. You should note that this benefit is not insured, and that all benefits are paid from your Participating Employer's general assets.

Amount You Can Elect

You may choose any amount of annual reimbursement up to $2,500. You will be required to make total annual contributions equal to the coverage level you have chosen.

When you complete the election form, you specify the amount of Health Care Reimbursement Program benefits you wish to pay for with your salary reduction. Thereafter, you make contributions for such

coverage by having a pro rata portion of the annual reimbursement amount deducted from each paycheck. Benefits are paid from your Participating Employer's general assets.

For example, suppose you have elected reimbursement benefits of $480 for a full year coverage period for eligible medical expenses. Your Health Care Reimbursement Account would be credited with a total of $480 for the coverage period. If you were paid semi-monthly, you would pay $20 each payday for your $480 of coverage under this part of the Plan.

Eligible Health Care Expenses

Eligible health care expenses are any items that are considered medical expenses under Code sections 105 and 213 for which you have not been reimbursed from insurance or otherwise. Generally, eligible health care expenses are expenses that could be deducted on your Federal income tax return plus certain additional items that are for "medical care" as defined under Code section 213(d). Eligible health care expenses may include expenses for yourself, your spouse, any person who is your tax dependent within the meaning of Code section 152 (without regard to certain limitations on your dependent's gross income, marital or filing status under certain Code rules) and any child (as defined in Code section 152(f)(1)) of a Participant who, as of the end of the calendar year in which the expense was incurred, has not attained age 27. For this purpose, the term "spouse" means a person of the opposite sex to whom you are married, as determined under the laws of the state in which you were married. You should note that the Code places additional restrictions on such expenses. For example, premiums for accident or health insurance are not eligible health care expenses. Consult your personal tax advisor or IRS Publication 502, "Medical and Dental Expenses," for further general guidance as to what can be an eligible health care expense. The Claims Administrator can also provide additional information about the types of expenses that are eligible for reimbursement.

Amounts Available for Reimbursement

While you continue to pay the periodic contributions due for your participation in the Health Care Reimbursement Program, the full amount of coverage you have elected will be available at any time during the coverage period, less any reimbursements you have received for eligible health care expenses incurred during such coverage period.

Receiving Reimbursement

If you elect to participate in the Health Care Reimbursement Program, you will have to take certain steps to be reimbursed for your eligible health care expenses. When you incur an expense that is eligible for reimbursement, you must submit a request for reimbursement from your Health Care Reimbursement Account to the Claims Administrator:

Benefit Resources, Inc.
4775 E. 91st Street, Suite 100
Tulsa, Oklahoma 74137

You must include with the request for reimbursement form a written statement or bill from an independent third party stating that an eligible health care expense has been incurred, the amount of such expense and, when required, a physician's statement or other documentation of the medical need for the service or supply. You must certify that the amount you are requesting for reimbursement is not reimbursable from any other source (excluding a health reimbursement account or HRA). You may also

be provided with a debit card to use for medical expenses, such as deductibles, co-pays, drug costs and medical equipment. The Claims Administrator will provide you with additional information.

To have your request for reimbursement processed as soon as possible, you should follow the instructions on the request for reimbursement form. Your reimbursement may be delayed or denied if you do not submit complete information. Please note that it is not necessary that you have actually paid an amount due for an eligible health care expense — only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

In addition, IRS regulations require that a medical service be actually rendered prior to the time that the eligible health care expense is reimbursed. Therefore, even if your doctor requires that an expense be paid in advance, you cannot be reimbursed under the Health Care Reimbursement Program until the service relating to the expense has been rendered.

Eligible health care expenses must have been incurred during the coverage period to which the request for reimbursement relates. This generally means that you may not be reimbursed for any expenses arising before the coverage period begins, before your salary reduction agreement becomes effective, or after the close of the coverage period. Also, you cannot be reimbursed for expenses in excess of the amount of coverage you elected.

You will have 60 days after the end of the coverage period to submit a request for reimbursement form for eligible health care expenses incurred during a coverage period. You will be notified in writing if any request for reimbursement is denied.

$500 Carryover and Forfeited Amounts

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual eligible health care expenses you have incurred for a coverage period and the coverage level you have elected and contributed for that coverage period.

Effective for coverage periods beginning on and after January 1, 2014, up to $500 of the unused balance in your Participant's Health Care Reimbursement Account as of the end of a coverage period will be carried over for use in the immediately following coverage period. Please contact the Claims Administrator for more information about carryovers. (Unused amounts from the 2013 coverage period will not be carried over to the 2014 coverage period.) Any credit remaining in your Health Care Reimbursement Account after the reimbursement cut-off date (described above) in excess of $500 **will be forfeited by you** and retained by the Participating Employers.

DEPENDENT CARE REIMBURSEMENT BENEFITS

As an Eligible Employee, you may be eligible to elect to receive tax-favored reimbursement for some or all of your work-related dependent care expenses under the Dependent Care Assistance Program.

Under the Dependent Care Assistance Program, you may elect a specific level of dependent care reimbursement benefits, paying for coverage through salary reduction in lieu of a corresponding amount of current pay. This arrangement helps you because the coverage you elect is generally nontaxable and you may save Social Security and income taxes on the amount of contributions you make.

Dependent Care Assistance Account

If you elect benefits under the Dependent Care Assistance Program, an unfunded, recordkeeping account ("Dependent Care Assistance Account") will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the contributions you make for such benefits during the coverage period. You should note that this benefit is not insured, and that all benefits are paid from your Participating Employer's general assets.

Amount You Can Elect

Under the Code, the maximum benefit you may elect is generally $5,000 per calendar year if you are:

- married and file a joint return
- married filing a separate tax return, but you are the custodial parent and furnish more than one-half the cost of supporting your eligible dependent child and either:
    - you have a decree of separate maintenance or written separation agreement, or
    - your spouse maintains a separate residence for the last 6 months of the calendar year, or
- single or a head of household for tax purposes.

If you are married and reside with your spouse but file a separate Federal income tax return, the maximum Dependent Care Assistance Program benefit you may elect is generally $2,500.

The benefit you elect cannot be more than your taxable earned income (after salary reduction under the Plan) or, if you are married, your spouse's actual or deemed earned income, if lower. Your spouse will be deemed to have earned income of $250 ($500 if you have expenses for the care of two or more dependents) for each month in which your spouse is (1) physically or mentally incapable of caring for himself or herself, or (2) a full-time student.

When you complete the election form, you specify the amount of Dependent Care Assistance Program benefits you wish to pay for with your salary reduction. Thereafter, you make contributions for such coverage by having a pro rata portion of the annual reimbursement amount deducted from each paycheck. Benefits are paid from your Participating Employer's general assets.

For example, suppose you have elected reimbursement benefits of $3,600 for a full year coverage period for eligible dependent care expenses. Your Dependent Care Assistance Account would be credited each pay period for your salary reduction amount up to a total of $3,600 for the coverage period. If you were paid semi-monthly, you would have a total of $150 credited to your Dependent Care Assistance Account each payday to pay reimbursements under this part of the Plan.

Amounts Available for Reimbursement

The amount that is available for reimbursement from your Dependent Care Assistance Account at any particular time during a coverage period will be whatever contributions you have made for the coverage period, less any reimbursements you have received for eligible dependent care expenses incurred during such coverage period.

Eligible Dependent Care Expenses

Note: Except in special circumstances, you can be reimbursed only for expenses for care of a dependent child under age 13.

You may be reimbursed only for eligible dependent care expenses that enable you and your spouse, if married, to be gainfully employed. Eligible dependent care expenses are those incurred for the care of:

- any individual in your family who is under age 13 and who you are entitled to claim as a dependent on your Federal income tax return;
- any other tax dependent (determined without regard to certain restrictions) who is mentally or physically incapable of caring for himself or herself; or
- your spouse, if your spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet all of the following conditions for them to be eligible dependent care expenses:

- the expenses are incurred for services rendered after the date of your election to receive Dependent Care Assistance Program benefits and during the coverage period to which a request for reimbursement relates
- any individual for whom you incur the expenses is a:
    - dependent under age 13 for whom you are entitled to a personal tax exemption as a dependent, or
    - your spouse or tax dependent (determined without regard to certain restrictions) who is physically or mentally incapable of caring for himself or herself
- the expenses are incurred for the care of a dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed
- if the expenses are incurred for services outside your household and such expenses are incurred for the care of a dependent who is age 13 or older, such dependent regularly spends at least eight hours per day in your home
- if the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations
- the expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or to an individual who is a tax dependent of yours or your spouse
- the reimbursement (when aggregated with all other dependent care expenses reimbursed during the same year, including reimbursements from a spouse's employer's plan) may not exceed the limits described under the above **Amount You Can Elect** heading

Receiving Reimbursement

If you elect to participate in the Dependent Care Assistance Program, you will have to take certain steps to be reimbursed for your eligible dependent care expenses. When you incur an expense that is eligible for reimbursement, you must submit a request for reimbursement from your Dependent Care Assistance Account to the Claims Administrator:

Benefit Resources, Inc.
4775 E. 91st Street, Suite 100
Tulsa, Oklahoma 74137

Eligible dependent care expenses must have been incurred during the coverage period to which your request for reimbursement relates. This generally means that you may not be reimbursed for any expenses arising before the coverage period begins, before your salary reduction agreement becomes effective, or after the close of the coverage period. Also, you cannot be reimbursed for expenses in excess of the amount available (your actual contributions minus prior benefit payments) under your Dependent Care Assistance Account.

To have your request for reimbursement processed as soon as possible, you should follow the instructions on the request for reimbursement form, including a written statement from the service provider as proof of the expense. Your reimbursement may be delayed or denied if you do not submit complete information. Please note that it is not necessary that you have actually paid an amount due for eligible dependent care expenses – only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source. The Claims Administrator will provide you with additional information.

You will have 60 days after the end of coverage period to submit a request for reimbursement form for eligible dependent care expenses incurred during a coverage period. You will be notified in writing if any request for reimbursement is denied.

Forfeited Amounts

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual eligible dependent care expenses you have incurred for a coverage period and the coverage level you have elected and contributed for that coverage period. Any credit remaining in your Dependent Care Assistance Account after the reimbursement cut-off date (described above) will be forfeited by you and retained by the Participating Employers.

Tax Considerations

Tax Identification Numbers

You will not normally be taxed on your Dependent Care Assistance Program benefits, up to the limits set out under the **Amount You Can Elect** heading above. However, to qualify for tax-favored treatment, you will be required to list on your annual income tax return the names and taxpayer identification numbers of any persons who provided you with dependent care services during the coverage period for which you have claimed reimbursement.

Dependent Care Credit

You may not claim any other tax benefit for the tax-favored amounts reimbursed to you under the Dependent Care Assistance Program, although your qualified dependent care expenses that are not reimbursed under the Dependent Care Assistance Program may be eligible for the dependent care credit.

The dependent care tax credit is an allowance for a percentage of your annual, qualified dependent care expenses as a credit against your Federal income tax liability. Because the actual determination of the preferable method for treating dependent care expenses depends on a number of factors such as your tax filing status (e.g., married, single, head of household) and number of dependents, each participant will have to determine his or her best tax position individually in order to make the decision between electing Dependent Care Assistance Program benefits or claiming the dependent care tax credit.

Keep in mind that tax laws change frequently. You should seek qualified tax advice when determining whether to elect salary reduction under the Dependent Care Assistance Program or claim the dependent care tax credit. More information about the dependent care tax credit may be found in IRS Publication 503, "Child and Dependent Care Expenses."

CLAIMS FOR BENEFITS

In General

Except with respect to claims for benefits under the Health Care Reimbursement Program, the documents governing each Benefits Program usually tell you when a claim for benefits must be filed, and how claims and appeals are handled for each program. This section provides information about a claim for benefits under the Health Care Reimbursement Program, and how appeals of denied claims are handled for Health Care Reimbursement Program benefits. These special claim and appeal rules do not apply to the Dependent Care Assistance Program.

You may not seek review of a denial of benefits prior to filing a claim for benefits under the Plan. You may not bring an action in court to enforce a claim for benefits prior to exhausting all rights to administrative review under the Plan. If you fail to file a claim or a request for review in accordance with the Plan's procedures, the claim shall be deemed denied and you shall have no right to review and shall have no right to bring any action in any court and the denial of the claim shall become final and binding on all persons for all purposes.

If you have designated an authorized representative, that person may act on your behalf in the claim or appeal process.

Initial Claim for Benefits

Once the Claims Administrator receives a properly filed claim from you or your provider, a benefit determination will be made within 30 days. This period may be extended one time for up to 15 additional days, if the Claims Administrator determines that additional time is necessary.

If the Claims Administrator determines that additional time is necessary, you will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make the determination.

Upon receipt of your claim, if the Claims Administrator determines that additional information is necessary in order for it to be a properly filed claim, the Claims Administrator will provide you with written notice of the specific information needed prior to the expiration of the initial 30-day period. You will have 45 days from receipt of the notice to provide the additional information. The Claims Administrator will notify you of its benefit determination within 15 days following receipt of the additional information.

If a claim for benefits is denied, in whole or in part, you or your beneficiary(ies) will receive written notice of the decision. The written notice will include the following:

- the specific reason(s) for the denial or decision
- specific reference to the Plan provision(s) on which the denial or decision was based
- a description of any additional material or information necessary to appeal the decision and an explanation of why it is necessary
- an explanation of the claim review procedure and the time limits applicable to such procedure, including your right to bring an action under ERISA section 502(a) following a denial on review
- if an internal rule, guideline, or protocol, or other similar criterion ("criterion") was relied upon in making the denial, either the:
    - specific criterion used, or
    - a statement that such criterion was relied upon in making the benefit denial and that a copy of such criterion will be provided free of charge upon request
- if the benefit denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the person's special medical circumstances, or a statement that such explanation will be provided free of charge upon request

Review of Claim Denial

The Plan has established the following process to review any dissatisfactions, complaints, and appeals. If you have a question or complaint, an initial attempt should be made to resolve the problem directly with the Claims Administrator. In most cases, the Claims Administrator will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through the appeal process described below. You must use the appeal process below before seeking a review of your claim in court.

You may request to review information used to make any adverse determination. Copies will be provided free of charge.

How and When to File an Appeal

If you are not satisfied with the initial attempt to resolve your problem, or if you wish to request a review of a benefit determination, you must request an appeal within 180 days from the date you received notice

that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court.

You must submit your request to the address of the Plan Administrator:

Oral Roberts University
Attn: Human Resources
7777 S. Lewis
Tulsa, Oklahoma 74171

The written request for an appeal should include your name and identification number, the nature of the complaint, the facts upon which the complaint is based, the resolution you are seeking, and the reason you feel your claim should not have been denied. Necessary facts include: dates and places of services, names of providers of services, types of services or procedures received and the corresponding medical need (if applicable). You should include any documentation that you want to be considered on review. The Plan Administrator may request further information if necessary.

Decisions on Appeal

Your appeal will be reviewed by an appropriate named fiduciary of the Plan who is not the same as (nor a subordinate of) the individual who made the initial review, and no deference will be afforded to the initial decision. In addition, a health care professional who has appropriate training and experience in the field of medicine may be consulted in regard to your claim. If this happens, or if any other medical or occupational expert is consulted in regard to you claim, you may request the identity of such person. The Plan Administrator will provide you a written decision on your appeal no later than 60 days following the date your appeal is received.

If your claim is denied on appeal, then you will generally receive the following information about the denial of the appeal:

- the specific reason(s) for the denial or decision
- specific reference to the Plan provision(s) on which the denial or decision was based
- a statement that you may have access to or copies of all documents or records that are relevant to your claim (without charge)
- a statement describing any voluntary appeals procedure offered by the Plan and a statement of your right to bring an action under Section 502(a) of ERISA
- if an internal rule, guideline, or protocol, or other similar criterion ("criterion") was relied upon in making the denial, either the
    - specific criterion used, or
    - a statement that such criterion was relied upon in making the benefit denial and that a copy of such criterion will be provided free of charge upon request
- if the benefit denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination,

applying the terms of the Plan to the person's special medical circumstances, or a statement that such explanation will be provided free of charge upon request

- a statement that advises you that you and the Plan may have other voluntary alternative dispute resolution options, such as mediation

CERTAIN LEGAL RIGHTS

Coverage During Family and Medical Leave

The rules and requirements under this heading apply only if the Family and Medical Leave Act of 1993, as amended, ("FMLA") applies to your Participating Employer and to your employment location. Contact Human Resources to learn whether you are eligible for FMLA leave.

If you take a leave of absence that is covered by the FMLA, you may drop an existing election under a Benefits Program providing group health coverage (including the Health Care Reimbursement Program) for the remaining portion of the coverage period. If your coverage under a Benefits Program providing group health coverage terminates while on FMLA leave (for example, by revocation or nonpayment of premiums), you may choose (but will not be required) to be reinstated in such coverage upon your return from FMLA leave, on the same terms as in effect prior to taking that leave. However, you will not have any greater rights to benefits for the remainder of the coverage period than if you had been continuously working during such period.

If you choose to continue your participation in a Benefits Program providing group health plan coverage (including the Health Care Reimbursement Program) during your FMLA leave, you must continue to pay the cost for your participation in such program(s) as in effect before your leave began, if any. You must pay the applicable amount on the same schedule as such payments would have been made if you were not on FMLA leave or any other payment schedule you agree to with your Participating Employer and permitted by applicable law (e.g., on a pre-pay basis). If you are on paid FMLA leave and you choose to continue your participation in a Benefits Program providing group health plan coverage (including the Health Care Reimbursement Program) during that leave, the cost for your participation will continue to be paid with pre-tax dollars through salary reduction.

If you fail to pay the cost for your participation in any Benefits Program while on FMLA leave, your Participating Employer may cancel your coverage. However, if your Participating Employer elects to continue your coverage in this situation, the Participating Employer may recoup your share of the cost of coverage from you at a later date.

While on FMLA leave, you have the same rights to change your elections under the Plan (including with respect to your coverage under a Benefits Program providing coverage other than group health) under the same terms and conditions that apply to participants in the Plan who are not on FMLA leave. See Appendix A to this Summary – Election Change Rules (attached) for more information.

COBRA Continuation Coverage

The rules and requirements under this heading describe the Consolidated Omnibus Budget Reconciliation Act ("COBRA") rules only with respect to your coverage under the Health Care Reimbursement Program.

The Plan offers no greater COBRA rights than what the COBRA statute requires, and this summary of COBRA rights should be interpreted accordingly. Additional COBRA rights may apply under a Benefits Program providing group health coverage other than the Health Care Reimbursement Program (the Employer's fully-insured major medical plan, for example). Contact your Participating Employer to learn about how COBRA may apply to such benefits.

COBRA rights in addition to those described under this heading may also apply to certain employees under a Federal law called the Trade Act of 2002 ("Trade Act"). Certain employees who have experienced a termination of employment or reduction in work hours with the Employer and who qualify for "trade readjustment allowance" or "alternative trade adjustment assistance" may qualify for additional COBRA rights under the Trade Act, including a second COBRA election period if COBRA was not elected when first available. Contact the Plan Administrator for additional information or if you qualify for assistance under the Trade Act.

Under COBRA, you and your eligible dependents can temporarily continue coverage in the Health Care Reimbursement Program (plus a small administrative fee) in certain instances where such coverage would otherwise be lost.

Employee Eligibility for Continuation Coverage

If you are covered under the Health Care Reimbursement Program as an eligible employee, you have the right to elect continuation coverage if you lose your coverage under the Health Care Reimbursement Program for either of these reasons:

- reduction in your hours of employment with your Participating Employer
- termination of your employment (including retirement) with your Participating Employer, for reasons other than your gross misconduct

Spouse Eligibility for Continuation Coverage

Your spouse who is covered under the Health Care Reimbursement Program as your eligible dependent has the right to elect continuation coverage if coverage under the Health Care Reimbursement Program is lost for any of these reasons:

- your death
- your reduction in hours of employment with your Participating Employer
- your termination of employment (including retirement) with your Participating Employer, for reasons other than gross misconduct
- your divorce or legal separation from your spouse
- your becoming entitled to Medicare

Child Eligibility for Continuation Coverage

Your child who is covered under the Health Care Reimbursement Program as your eligible dependent has the right to elect continuation coverage if coverage under the Health Care Reimbursement Program is lost for any of these reasons:

- your death
- your reduction in hours of employment with your Participating Employer
- your termination of employment (including retirement) with your Participating Employer, for reasons other than gross misconduct
- your divorce or legal separation from your spouse
- your becoming entitled to Medicare
- your child ceases to be an eligible dependent under the Health Care Reimbursement Program

A child who is an eligible dependent born to or placed for adoption with the covered employee during a period of continuation coverage is also a qualified beneficiary for whom continuation coverage may be elected.

Notice of Qualifying Event

Under Federal law, the employee or a family member has the responsibility to tell the Plan Administrator within 60 days of a divorce, legal separation or a child's loss of dependent status under the Health Care Reimbursement Program. If this notice deadline is not met, the notice will be rejected as untimely and the right to COBRA continuation will be lost. See the **How to Notify the Plan** heading below.

Your Participating Employer has the responsibility to tell the Plan Administrator of the employee's death, termination of employment, reduction in work hours or Medicare entitlement.

The Plan Administrator will send you a COBRA election form after it learns that you would otherwise lose coverage due to an event described above.

Election Period

You have a 60-day election period to tell the Plan Administrator that you want COBRA continuation coverage. This 60-day election period begins on:

- the date you would lose coverage because of one of the events described above, or
- if later, the date your Participating Employer provides you notice of your right to elect continuation coverage

To elect COBRA continuation coverage, the COBRA election form must be sent and postmarked no later than the 60th day of your election period. The COBRA election form should be directed to the Plan

Administrator. You may also hand deliver your election to the Plan Administrator at the same address so long as it is actually received by the last day of the election period.

Continuation Coverage, Your Choice

If you do not elect continuation coverage, your group health coverage under the Health Care Reimbursement Program will end.

If you elect continuation coverage, you will receive coverage that is the same as the Health Care Reimbursement Program coverage being provided to similarly situated non-COBRA beneficiaries. This means that if the Health Care Reimbursement Program changes for similarly situated non-COBRA beneficiaries, the changes will also apply to you.

Qualified beneficiaries (including those who are not former employees) can change their coverage or add dependents to their coverage the same as active employees. A dependent added to a qualified beneficiary's continuation coverage generally is not a qualified beneficiary and is not entitled to make separate continuation coverage elections. But, a child who is born to or placed for adoption with a qualified beneficiary who was a covered employee is a qualified beneficiary.

Considerations for Electing COBRA Continuation Coverage

In considering whether to elect COBRA continuation coverage with respect to the Health Care Reimbursement Program, you should take into account the contributions for coverage you have made and the reimbursements you have received during the coverage period. If you do not elect COBRA continuation coverage, then only eligible expenses which you have already incurred prior to termination of your participation in the Health Care Reimbursement Program may be submitted for reimbursement. Expenses incurred after termination of participation in the Health Care Reimbursement Program cannot be reimbursed.

If you reject COBRA continuation coverage before the end of your 60-day election period, you may change your mind as long as you submit a completed election form before the end of your election period.

Length of Continuation Coverage

The maximum period of COBRA continuation coverage is the end of the Health Care Reimbursement Program's Plan Year in which the qualifying event occurs. The Health Care Reimbursement Program's Plan Year is the calendar year.

Your continuation coverage under COBRA will end earlier than the maximum period described above if:

- your Participating Employer no longer provides group health coverage to any of its employees.
- you do not pay your COBRA premium when due. See the Continuation Payment discussion under this heading.
- you (or a covered eligible dependent) first become covered, after your COBRA election, as an employee or otherwise under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary. This means that other group health coverage in effect on or before the date of your COBRA election will not cause your COBRA coverage to end.

- you (or a covered eligible dependent) first become entitled, after your COBRA election, to Medicare. This means that Medicare coverage in effect on or before the date of your COBRA election will not cause your COBRA coverage to end.

- any event happens that permits termination of Health Care Reimbursement Program coverage for cause with respect to covered eligible employees or their covered eligible dependents who have coverage under the Health Care Reimbursement Program for a reason other than continuation coverage (*e.g.,* submission of fraudulent benefit claims).

Coverage that has been canceled for any of these reasons cannot be reinstated. You must notify the Plan Administrator as soon as reasonably possible if, after electing COBRA continuation coverage, you obtain other group health plan coverage or Medicare benefits as described above. See the **How to Notify the Plan** heading below.

If you fail to provide notice of an event that causes your COBRA continuation coverage to terminate before the end of the maximum continuation period (for example, due to obtaining other coverage), the Plan Administrator will terminate your coverage retroactively to the date coverage otherwise would have ceased.

Interaction with Family and Medical Leave

The start of a leave of absence covered by the Family and Medical Leave Act of 1993 (see the **Coverage during Family and Medical Leave** heading) is not a COBRA qualifying event. A COBRA qualifying event does not occur for a Family and Medical Leave Act leave unless the employee does not return to work after the end of such leave.

Continuation Coverage Cost

You do not have to show that you are insurable to begin continuation coverage. However, under Federal law, you must pay for your continuation coverage. The cost to you is 102% of the Health Care Reimbursement Program's cost for your coverage.

Continuation Payments

Your payment for COBRA continuation coverage must be sent (and postmarked) within 45 days of the date you first submit a completed COBRA election form. In most cases, your payment for COBRA continuation coverage should be directed to the Plan Administrator unless you are advised otherwise.

You must send payment to cover the number of months from the date of regular coverage termination to the time of payment. Partial payment will not be accepted and can prevent COBRA continuation coverage from taking effect. If your first payment for COBRA continuation coverage is not made in full within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

You must submit the monthly continuation payment (unless you have been advised of a change) each month thereafter by the payment due date. The payment due date for each month of coverage is the first day of that month. You have a 30-day grace period from that date to make your continuation payment. For example, payment for coverage during the month of December is due on December 1. Payment on or before December 1 will prevent delays in benefit payments and other disruptions in coverage. However,

if you cannot pay for December coverage promptly on December 1, you may have a grace period until December 30 to pay for December coverage.

If you fail to pay by the end of the grace period, **your coverage will cease** as of the end of the period for which payment has been timely made and cannot be reinstated. A check that has been returned unpaid from the bank for any reason may result in untimely payment and can result in cancellation of coverage. Please note that you may not be billed for COBRA coverage.

How to Notify the Plan of Qualifying Event and Other Events

To notify the Plan Administrator of a qualifying event or provide other required notices described above, you must provide written notice to the Plan Administrator by the applicable deadline with the information described below. If you fail to meet the notice deadline, your notice will be rejected as untimely.

If you mail your notice, it must be postmarked no later than the last day of the notice period and be addressed to the Plan Administrator.

You may also hand deliver your notice so long as it is actually received by the Plan Administrator during business hours by the last day of the applicable notice. The election form may allow you to use other means of notice.

Your notice must include the following information, as applicable:

- The name of the Plan,
- The full name and address of the employee covered under the Plan,
- The full name(s) and address(es) of the affected qualified beneficiary(ies) and any other covered person(s),
- A description of the qualifying event and the date it occurred,
- If the notice relates to a qualifying event that is a divorce or legal separation, a copy of the divorce or separation order.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Any COBRA notices and elections made by an employee or family member must be in writing and provided to the following address via U.S. mail or hand delivery (or as otherwise directed or permitted from time to time by the COBRA administrator on behalf of the Plan Administrator):

Benefit Resources, Inc.
4775 E. 91st Street, Suite 100
Tulsa, Oklahoma 74137-2804

For More Information

This summary does not fully describe many rights under the Plan. More information about your rights under the Plan is available from the Plan Administrator.

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

Continuation of Coverage for Military Leave

If you are going into or returning from military service you may have certain rights to continued Health Care Reimbursement Program benefits under a Federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are an eligible employee covered by the Health Care Reimbursement Program who becomes absent from employment with a Participating Employer due to military service, the Participating Employer will treat your military leave as an approved unpaid leave of absence to the extent required by USERRA. If this happens, you will generally be entitled to all the rights and benefits under the Health Care Reimbursement Program that are available to any other covered eligible employee on an approved unpaid leave of absence. Contact your Participating Employer for more information.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the operation of the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- You may be entitled to continue health care coverage for yourself or your eligible dependents if there is a loss of coverage under the Health Care Reimbursement Program as a result of a qualifying event. You or your eligible dependents will have to pay for such coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- if you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court, after exhausting all of your appeal rights.

- if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court, after exhausting all of your appeal rights.

- if it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

- the court will decide who should pay each party's court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Newborns' and Mothers' Health Act

The Health Care Reimbursement Program does not limit benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a vaginal delivery, or
- 96 hours following a cesarean section

However, the mother's or newborn's attending provider can decide to discharge the mother or her newborn earlier than these timeframes, but only if the mother agrees.

A provider does not need authorization for prescribing a length of stay in connection with childbirth for up to 48 hours (or 96 hours following a cesarean section).

Women's Health and Cancer Rights Act Benefits

As required by the Women's Health and Cancer Rights Act of 1998, benefits under the Health Care Reimbursement Program are payable for covered expenses incurred by a person covered under the Health Care Reimbursement Program for mastectomy-related services including:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema

For more information about mastectomy-related services covered by the Health Care Reimbursement Program, contact the Plan Administrator.

Qualified Medical Child Support Order

The Plan complies with certain qualified medical child support orders ("QMCSOs") for medical benefits. To be a QMCSO, a child support order must be entered by a court of competent jurisdiction or issued through a state administrative process that has the force of law.

To be a QMSCO, the order must also include all of these things (as determined in the sole discretion of the Plan Administrator):

- the employee's name and address
- the name and address of any child covered by the order
- a reasonable description of the type of coverage to be provided to the child or how to decide the type of coverage
- the period to which the order applies

- the name of each plan to which the order applies

In addition, these rules apply to QMSCOs:

- a QMCSO cannot require the Plan to provide any benefit or option not otherwise provided by the Plan, unless required under the Social Security law.
- you will have to pay for the cost of Plan coverage. The Employer will tell you how much Plan coverage costs.
- all applicable Plan rules apply to the coverage.
- if you are eligible but not already enrolled in the Plan, you will be enrolled at the same time as the child.

The Plan Administrator will treat any appropriately completed "National Medical Support Notice" that meets the rules under this heading as a QMCSO. The Plan follows certain procedures for QMCSOs. Ask the Plan Administrator for a copy of these procedures (free of charge).

OTHER PLAN INFORMATION

Authority of Plan Administrator

The Plan Administrator has the sole and exclusive responsibility for the management, interpretation, and administration of the Plan. It has the full discretion and authority to determine eligibility for participation and benefits and to review claims for benefits.

All interpretations of the Plan and all questions concerning its administration and application, including any eligibility determinations and any claim for benefits, shall be determined by the Plan Administrator (or its delegate) in its sole and absolute discretion, and such determination shall be conclusive and binding on all persons to the maximum extent permitted by law.

No Guarantee of Employment

Nothing in the Plan or this Summary guarantees your right to employment with a Participating Employer.

No Guarantee of Tax Savings

The Plan is intended to comply with tax laws that can provide tax savings to participants. However, the Employer cannot and does not guarantee that the tax savings opportunities generally described in this Summary will apply in all situations.

Amendment or Termination of the Plan

The Employer reserves the right to amend the Plan and its component programs and policies at any time. The Employer further reserves the right to terminate the Plan and any of its programs and policies at any time and for any reason without the consent of any employee.

Participant's Responsibility

Participation in the Plan requires that you provide the Plan Administrator and any third party administrator with the information requested upon your initial eligibility and from time to time thereafter for purposes of operating and administering the Plan. Your failure to provide such information may result, in the discretion of the Plan Administrator, in the delay or denial of benefits under or participation in the Plan or in any other action determined in the discretion of the Plan Administrator as necessary or appropriate for purposes of operating and administering the Plan. In addition, participation in the Plan requires that you provide the Plan Administrator with your current address. Any notices required or permitted to be given under the Plan shall be deemed given if directed to such address and mailed by regular United States mail. The Plan Administrator does not have any obligation or duty to locate you.

Missing Persons / Uncashed Checks

Any amount due under the Plan that has not been claimed (including uncashed checks) within two (2) years of becoming payable will be forfeited. Any amount so forfeited will no longer be a liability of the Plan, provided that the Plan Administrator has exercised due and proper care in attempting to make such payment.

Right of Recovery

If the Plan Administrator or a Participating Employer makes any payment(s) in excess of any amount required under the Plan, the Plan Administrator shall have the right to recover the excess payment(s) from any person who received the excess payment(s). Such recovery may include a corresponding reduction of any future payment due to the Participant or beneficiary under the Plan. Any such recovery shall be returned to the Participating Employer which made the excess payment.

Governing Law

The Plan shall be governed by and construed in accordance with applicable Federal laws governing employee benefit plans, including ERISA, and in accordance with the laws of the State of Oklahoma where such laws are not preempted by or in conflict with such Federal laws. Any action arising out of or relating to the Plan must be brought in a court with jurisdiction and venue in Tulsa County, Oklahoma.

Additional Plan Information

Employer, Plan Sponsor and Plan Administrator:

Oral Roberts University
7777 S. Lewis Ave.
Tulsa, OK 74171
(918) 495-7561

Other Participating Employer:

- University Broadcasting, Inc.

Name of Plan: Oral Roberts University Flexible Benefits Plan

Plan Sponsor's Employer Identification Number: 73-0739626

Agent for Legal Process:

Terry M. Kollmorgen
Moyers, Martin, Santee & Imel, LLP
401 S. Boston, Suite 1100
Tulsa, OK 74103
(918) 582-5281

Type of Plan: The plan is a cafeteria plan and a dependent care assistance program within the meaning of Internal Revenue Code sections 125 and 129. The Health Care Reimbursement Program is a welfare plan and is part of the Oral Roberts University Group Benefits Plan. The ERISA plan number for the Group Benefits Plan is 501. The plan year for the Group Benefits Plan is the 12-month period beginning on December 1.

Funding: Plan benefits are paid from general assets of the Participating Employers (uninsured benefits) and insurance company payments (insured benefits).

Claims Administrator for the Health Care Reimbursement Program and the Dependent Care Assistance Program:

Benefit Resources, Inc.
4775 E. 91st Street, Suite 100
Tulsa, Oklahoma 74137

DEFINITIONS

The following definitions apply to the Plan.

Benefits Program. An employee benefits program designated as such in the **General Information About the Plan** section above.

Claims Administrator. Benefit Resources, Inc.

Code. The Internal Revenue Code of 1986, as amended.

Dependent Care Assistance Program. An employee benefits program providing dependent care assistance benefits to eligible individuals. The Dependent Care Assistance Program is a Benefits Program under the Plan.

Election Change Event. An event described in Appendix A to this Summary – Election Change Rules (attached) which, at the Plan Administrator's determination, allows an individual to make certain changes to his Plan election during a coverage period.

Employer. Oral Roberts University.

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

Health Care Reimbursement Program. An employee benefits program providing health care reimbursement benefits to eligible individuals. The Health Care Reimbursement Program is a Benefits Program under the Plan.

Participating Employer. The Employer and any other entity identified as a Participating Employer.

Plan Administrator. Oral Roberts University.

APPENDIX A

to the Oral Roberts University Flexible Benefits Plan Summary

Election Change Rules

Your election of benefits under a Benefits Program for a coverage period is generally irrevocable with respect to that coverage period, except that you may be entitled to make certain changes to your election(s) during a coverage period if you experience an Election Change Event as described in this Appendix A to the Summary.

The Plan Administrator determines, in its sole discretion, whether you have experienced an Election Change Event described below and have satisfied the conditions for any related election change you may request. In addition to the conditions and limitations governing election change requests described below, any election change request is also subject to the conditions and limitations under the document(s) governing the Benefits Program(s) to which the election change request relates, unless otherwise required by law.

The Plan's election change rules generally determine when you can change your election under the Plan. This is only a summary of the rules. Contact the Plan Administrator with questions about whether you have experienced an Election Change Event described below, to learn more about the types of election changes you may make, or to request a copy of the governing documents for the Plan.

Election Change Events and the types of election changes you may make in relation to such events are described below.

Change in Status

An Election Change Event includes any one of the following changes in status if such a change affects eligibility under this Plan or another employer plan:

- a change in your legal marital status, including marriage, death of spouse, divorce, legal separation and annulment
- a change in the number of your dependent children, including birth, death, adoption and placement for adoption
- certain changes in your employment status or that of your spouse or a dependent child (for example, a change from full-time to part-time)
- your dependent child's becoming eligible for or ceasing to satisfy the plan's eligibility requirements
- a change in the place of your residence or that of your spouse or a dependent child

If you experience an Election Change Event as described above, you may make an election change that is on account of and corresponds with the change in status that affects eligibility for coverage under an employer's plan (the "Consistency Rule"). Here are some key points to keep in mind about the Consistency Rule:

may revoke your election under the Plan and, in lieu thereof, elect the new or improved coverage option, except that no change may be made for this Election Change Event with respect to the Health Care Reimbursement Program. The Plan Administrator determines whether there is a new or significantly improved benefit package option or other coverage option.

- *You, your spouse or your dependent has a significant curtailment in coverage under the Plan.* If this Election Change Event happens, you may make the election changes described below, except that no change may be made for this Election Change Event with respect to the Health Care Reimbursement Program. Coverage is significantly curtailed only if there is an overall reduction in the coverage provided so as to constitute reduced coverage generally.

  - ✓ Significant Curtailment without Loss of Coverage. If the Plan Administrator determines that your, your spouse's or your dependent's coverage under the Plan is significantly curtailed without a loss of coverage, you may revoke your election for that coverage and, in lieu thereof, elect coverage under another benefit package option that provides similar coverage.

  - ✓ Significant Curtailment with Loss of Coverage. If the Plan Administrator determines that your, your spouse's or your dependent's coverage under the Plan is significantly curtailed such that the curtailment results in a loss of coverage, you may revoke your election for that coverage, and in lieu thereof, (A) elect coverage under a benefit package option that provides similar coverage or (B) drop coverage if no benefit package option is available that provides similar coverage.

- you are required to enroll or allowed to drop coverage for a child pursuant to a judgment, decree, or order ("Order").

  - If an Order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order as defined in section 609 of ERISA, requires accident or health coverage for your dependent child, you may: (i) change your election to provide coverage for the child if the Order requires such coverage; or (ii) change your election to cancel coverage for the child if the Order requires that another individual (including your spouse or former spouse) provide coverage for such child and such coverage is, in fact, provided.

- you, your spouse or a dependent child becomes entitled to or loses coverage under Medicare or Medicaid (other than coverage consisting solely of pediatric vaccines).

  - If you, your spouse or your dependent who is enrolled in an accident or health plan under the Plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (relating to distribution of pediatric vaccines), you may make an election change to reduce or cancel the accident or health coverage of the individual becoming entitled to Medicare or Medicaid. In addition, if you, your spouse or your dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, you may make an election to increase or commence

accident or health coverage under the Plan for the individual who lost such Medicare or Medicaid eligibility.

- you, your spouse or a dependent child loses group health coverage sponsored by a governmental or educational institution.

  - If you, your spouse or your dependent child loses coverage under a group health plan sponsored by a governmental or educational institution including: (i) a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian tribal government (as defined in Code section 7701(a)(40)), the Indian Health Service, or a tribal organization; (iii) a state health benefits risk pool or (iv) a Foreign government group health plan, you may make an election to add health coverage for the individual who lost such coverage, except that no change may be made for this Election Change Event with respect to the Health Care Reimbursement Program.

- a special enrollment under HIPAA.

  - If you, your spouse or your dependent is entitled to a HIPAA special enrollment right (as defined under Code section 9801(f)), you may revoke an election with respect to group health plan coverage and make a new election that corresponds with the HIPAA special enrollment right.