ORAL ROBERTS UNIVERSITY

GROUP BENEFITS PLAN SUMMARY

Effective January 1, 2015

INTRODUCTION

Oral Roberts University provides the Group Benefits Plan ("Plan") for its Eligible Employees and those of any Participating Employer. This Group Benefits Plan Summary ("Summary"), together with the Benefits Descriptions described below, is called a summary plan description and describes the benefits available under the Plan for Eligible Employees and Eligible Dependents.

This Summary includes many of the Plan's important rules about Plan benefits. This Summary does not contain every detail of the Plan or all of its specific terms. No person will gain any new rights under the Plan because of a misstatement in or omission from this Summary or by operation of the Plan. You may obtain a copy of the Plan's governing documents from the Plan Administrator.

The Plan includes the following insured benefits programs for Eligible Employees:

- Basic and voluntary life insurance program
- Basic and voluntary accidental death and dismemberment (AD&D) insurance program
- Short term and long term disability insurance program
- Employee assistance program

The Insurer for each insured benefits program has prepared a Benefits Description that tells about the benefits under that program. The Benefits Descriptions that describe your benefits are provided to you by the Plan Administrator separately from this Summary. Each Insurer of your benefits may call its Benefits Description (which may be one or more documents) a "Certificate of Coverage," "Evidence of Coverage," "Summary of Coverage," or something similar. We call all of the Insurers' documents that describe and govern your benefits the "Benefits Descriptions."

The Plan also includes the following self-funded benefits programs, which are described in separate summary documents (also referred to as Benefits Descriptions"):

- Medical insurance program
- Dental insurance and vision discount program
- Health care reimbursement program (also known as a "health care flexible spending account)

The terms of the health care reimbursement program (health care flexible spending account) are described in the Summary for the Oral Roberts University Flexible Benefits Plan.

The benefits programs may have multiple coverage options, which will be described in the Benefits Descriptions.

Neither this Summary nor the benefits provided by the Plan are a promise of continued employment. The Employer may amend or terminate the Plan at any time. If the Plan is amended or terminated, Plan benefits may be different from those summarized or may end completely.

Together, this Summary and the related Benefits Descriptions describe your benefits under the Plan and other important information about your Plan rights, duties, responsibilities and restrictions. At times, this Summary directs you to detailed information found in a Benefits Description. When this happens, the information in the Benefits Description should be treated as part of this Summary. This Summary is not intended to give you any substantive rights to benefits that are not already provided under Benefits Descriptions for the various benefits programs.

WORDS AND PHRASES WITH SPECIAL MEANINGS

This Summary contains a number of words and phrases that have special meanings under the Plan and this Summary. These words and phrases (sometimes called "defined terms") are capitalized in this Summary. The special meanings of these words and phrases appear in the **Glossary** section of this Summary. You should carefully review the special meanings in the **Glossary** to understand your rights, benefits and duties under the Plan.

GENERAL ELIGIBILITY RULES

Eligibility

If you are an employee of Oral Roberts University, you are an Eligible Employee if you are a:

- regular faculty member who is considered "full time" as defined in the faculty contract, or

- regular full-time non-faculty staff employee. For benefits programs other than the medical insurance program and the health care reimbursement program, "full-time" means you regularly work at least 40 hours per week. For the medical insurance program and the health care reimbursement program, "full-time" means you regularly work at least 30 hours per week.

If you are an employee of University Broadcasting, Inc., you are an Eligible Employee if you are a regular full-time employee. For benefits programs other than the medical insurance program and the health care reimbursement program, "full-time" means you regularly work at least 40 hours per week. For the medical insurance program and the health care reimbursement program, "full-time" means you regularly work at least 30 hours per week.

> **Note:** An employee who is not eligible to participate in the medical insurance program according to the above rules can become eligible to participate as provided in Appendix A, "Special Rules for Certain Part-Time Employees". These rules do not apply to any other benefits under the Plan.

For purposes of the Plan's eligibility provisions, the term "employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll.

Any regular employee of a Participating Employer is eligible to utilize the services of the employee assistance program without any enrollment required.

The following individuals are <u>not</u> eligible for participation in the Plan:

- a part-time, temporary, seasonal, contract or project-based employee of a Participating Employer (except, for the medical insurance program, as provided in the section titled "Special Rules for Certain Part-Time Employees");

- a non-resident alien who receives no income from a Participating Employer that is considered income from sources in the United States;

- an individual who has a written contract with a Participating Employer stating either that the individual is not an employee or is not entitled to participate in the employee benefit plans of the Participating Employer;

- a leased employee or any individual classified by a Participating Employer as a contract worker or independent contractor for the period during which such individual is so classified, whether or not such individual is subsequently determined by any government agency, any court or any other person or entity to be a common-law employee of the Participating Employer; or

- any individual who performs services for a Participating Employer but is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is subsequently determined by any government agency, any court or any other person or entity to be a common-law employee of the Participating Employer.

If you are an Oral Roberts University regular faculty member who is an Eligible Employee, your eligibility date for all benefits programs is the effective date of your full-time faculty contract. For all other eligible employees, your eligibility date is the first day of the calendar month following your date of hire.

To have coverage begin on your eligibility date described above, you must complete and submit any required enrollment forms within 30 days after your date of hire (or the effective date of your faculty contract, if applicable). 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, subject to any further restrictions under each benefits program.

Please note that the eligibility and enrollment provisions above are 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 eligibility and enrollment restrictions.

ENROLLMENT RULES

How to Enroll

To enroll for coverage, you must do all of these things:

- Complete the applicable enrollment form(s), as required by the Plan Administrator.

- File any required form with the Plan Administrator during an enrollment period. The "When to Enroll and Effective Date of Coverage" heading below in this section tells about the enrollment periods.

- Pay any required cost for coverage.

You must enroll yourself if you also want to enroll your Eligible Dependents. You can enroll your Eligible Dependents the same way you enroll yourself. If you and your spouse are both Eligible Employees, only one of you can enroll your Eligible Dependents for coverage. Also, a person cannot be covered under the Plan both as an Eligible Employee and as an Eligible Dependent.

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.

When to Enroll and Effective Date of Coverage

> **Note:** If you become eligible for the medical insurance program under the rules described in Appendix A, "Special Rules for Certain Part-Time Employees", you will receive notice of when and how you may enroll for coverage, which may be different from the procedures described in this section.

As an Eligible Employee, you can enroll yourself and your Eligible Dependents for Plan coverage only during one of these enrollment periods:

- The **initial enrollment period**. The initial enrollment period is 30 days after your date of hire.

- The **annual enrollment period**. Generally, this is held before the start of each coverage period. During this period, all Eligible Employees can enroll themselves and their Eligible Dependents, subject to any additional restrictions in each benefits program. The Plan Administrator will tell you when the annual enrollment period occurs.

- A **special enrollment period** for medical insurance coverage. This is for certain persons who have lost other group health coverage and for certain new dependents. The "Special Enrollment Period" heading under this section describes the rules for special enrollment.

If you do not enroll during the initial enrollment period or during a special enrollment period (if one applies), you will be a "late enrollee." A late enrollee must generally wait to enroll during the next annual enrollment period. This will delay coverage. For certain benefits programs, you or your dependent may be required to provide evidence of good health if you do not enroll during your initial enrollment period.

Once your enrollment period ends, you generally cannot cancel or change your coverage until the next annual enrollment period. There is a special exception to this rule if you have a change in status or election change event. The "Changing Your Coverage" heading under this section tells generally when you have a change in status or other election change event and how you can cancel or change your coverage.

Special Enrollment Period – applicable only to the Medical Insurance Program

<u>Loss of Other Coverage</u>

A special enrollment period is available when all of these things happen:

- You are an Eligible Employee and you (or your Eligible Dependents) lose coverage under another group health plan after first becoming eligible under this Plan.

- The other group health plan coverage was either:

    - COBRA continuation coverage for which the continuation period ended, or

    - Other group health care coverage that ended either because employer contributions toward the cost of coverage were terminated or because eligibility ended due to age, legal separation, divorce, cessation of dependent status, death, termination of employment or

reduction in work hours or termination of benefits for a class of individuals that includes the individual.

- The other group health plan coverage was not terminated for cause (such as making a fraudulent claim or an intentional misrepresentation) or for nonpayment of contributions.

- You file a completed enrollment form with the Plan Administrator during the special enrollment period.

The Benefits Description may impose additional limitations on when loss of other coverage triggers special enrollment rights.

The special enrollment period for persons who have lost other group health coverage is the 30 day period after the date the COBRA coverage is exhausted, the date the employer contributions are terminated or the date other group coverage is lost for a different reason. This means that you have 30 days after one of these events to file the completed enrollment form with the Plan Administrator.

If you enroll during a special enrollment period due to loss of other coverage, your medical coverage will generally be effective as of the first day of the calendar month following the date your enrollment request is received by the Plan Administrator.

New Eligible Dependents

A special enrollment period is also available to certain new Eligible Dependents. If a person becomes your Eligible Dependent through marriage, birth, adoption or placement for adoption, that person may be eligible for a special enrollment period. These rules apply to the special enrollment period for new Eligible Dependents:

- You cannot enroll a new Eligible Dependent unless you are already enrolled or enroll yourself during this special enrollment period.

- You can also enroll your un-enrolled spouse during this special enrollment period if there is a birth or adoption and your spouse is otherwise an Eligible Dependent.

The special enrollment period for new Eligible Dependents is the 30 day period after the date of the marriage, birth, adoption or placement for adoption. This means that you have 30 days after one of these events to file with the Plan Administrator the completed enrollment form.

The Benefits Descriptions may impose additional limitations on when new Eligible Dependents trigger special enrollment rights.

If your or Eligible Dependent's enrollment is due to acquisition of a new Eligible Dependent as a result of birth, adoption or placement for adoption, medical coverage for you and/or your Eligible Dependent will generally be effective as of the date of the birth, adoption or placement for adoption.

If your or Eligible Dependent's enrollment is due to acquisition of a new Eligible Dependent as a result of marriage, medical coverage for you and/or your Eligible Dependent will generally be effective as of the first day of the calendar month following the date the enrollment request is received by the Plan Administrator.

Gaining or Losing Health Coverage State Assistance

You may be able to enroll yourself and your dependents in the Plan later than your initial enrollment period if:

- you or a dependent loses coverage under Medicaid or a state child health insurance program, or
- you or a dependent becomes eligible for group health plan premium assistance under Medicaid or a state child health insurance program.

You must request enrollment in the Plan and file a completed enrollment form within 60 days of losing such other coverage or gaining premium assistance eligibility.

CHANGING YOUR COVERAGE

In General

As an Eligible Employee covered by the Plan, your Plan enrollment election will usually continue until you cancel or change your election. You can cancel or change your Plan enrollment election only if one of these things happens:

- The Plan has its annual enrollment period.
- For the medical insurance program and the dental insurance program, the type of event described in the Employer's cafeteria plan occurs that lets you cancel or change your Plan enrollment election.

Your ability to change your election, if applicable, with respect to life, AD&D and disability coverage is subject to the terms of the insurance policies governing those benefits.

Generally, you are not permitted to change your health care reimbursement program election at any time other than the annual enrollment period.

Please note that an enrollment election or an election change described in this Summary is also subject to any conditions or restrictions of the applicable benefits programs. This means that you may not be able to change your election for a particular benefits program upon all events described in this Summary.

Change of Elections – Medical Insurance Program and Dental Insurance Program

For the medical insurance program and the dental insurance program, the Employer's cafeteria plan (the Oral Roberts University Flexible Benefits Plan) election change rules generally determine when you can change your election under this Plan for changes other than for an initial or annual enrollment. The plan administrator of the cafeteria plan will decide in its discretion if your request for an election change is permitted under that plan.

The types of events for which you may change your Plan enrollment election are generally summarized under this heading. However, this is only a summary of the rules. Application of a cafeteria plan's election change rules to this Plan does not otherwise expand this Plan's eligibility rules. Contact the plan administrator of the cafeteria plan for a copy of that plan's document.

Change in Status

Certain changes in your medical and dental insurance program enrollment election may be permitted under a cafeteria plan when you have a change in status that affects eligibility under this Plan or another employer plan, including:

- 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.
- 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.

Any election change made pursuant to a change in status must be on account of and correspond with the change in status that affects eligibility for coverage under an employer's plan.

Other Election Change Events

Certain changes in your Plan medical and dental insurance program enrollment election may be permitted under a cafeteria plan if you have additional election change events, such as:

- If you have certain changes in the cost or coverage of benefits.
- If you are required to enroll or allowed to drop coverage for a child pursuant to a judgment, decree, or order.
- If 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 a dependent child loses group health coverage sponsored by a governmental or educational institution.
- If a special enrollment under HIPAA occurs.

Notification

You have only a limited amount of time to request an enrollment election change. It is your responsibility to tell the Plan Administrator if you want to change your Plan enrollment election on account of a change in status or other election change event. Generally, you have 30 days after the date of a change in status or other election change event in which to request a change in your Plan enrollment election. Contact the Plan Administrator for the form necessary to file your request.

PARTICIPANT CONTRIBUTIONS

Persons enrolled in the Plan are usually required to pay some part of the cost of their Plan coverage. The Plan Administrator will tell Eligible Employees the cost of coverage prior to enrollment. As an Eligible Employee covered by the Plan, you may be able to pay for your own medical, dental and health care reimbursement program coverage and for coverage for certain Eligible Dependents with pre-tax dollars under a cafeteria plan.

Participant contributions for coverage under this Plan that are paid on a pre-tax basis under the Employer's cafeteria plan are subject to certain nondiscrimination rules under the Internal Revenue Code. These rules are designed by the IRS to ensure that certain individuals – namely, highly compensated participants and key employees – do not receive disproportionate benefits under a tax-favored plan such as the cafeteria Plan. If the cafeteria Plan fails nondiscrimination testing for a given year, highly compensated and/or key employee participants are generally taxed on the amount of their pre-tax contributions, including any dependent coverage, made during that year. The plan administrator of the cafeteria Plan also reserves the right to adjust a participant's pre-tax contribution election to confirm compliance with the nondiscrimination rules or other legal requirements.

PLAN BENEFITS

Except as otherwise described below with respect to any self-funded benefits, the Plan pays only the benefits it has contracted with the Insurer to provide. The Insurers have prepared Benefits Descriptions that describe the benefits available under the Plan for enrollees in each Insurer's coverage option. The Benefits Descriptions also tell some special rules for obtaining these benefits. The Benefits Descriptions provide you with detailed benefits information. When this Summary refers to the Benefits Descriptions for certain information, you should treat that information in the Benefits Descriptions as part of this Summary.

Any self-funded benefits available under the Plan are described in the Benefits Descriptions. For any part or all of a benefits program that is self-funded, the Employer funds the benefits and uses an administration company to administer claims. The Plan pays only the self-funded benefits described in the Benefits Descriptions, if any. The Benefits Descriptions also tell any special rules for obtaining self-funded benefits.

In General

The Benefits Descriptions tell you:

- What types of benefits are provided under the Plan.
- How the Insurer determines how much it will pay.

You should also read the Benefits Descriptions for other important benefits information such as:

- Cost-sharing rules, including when you are required to pay any deductible, coinsurance or co-payment amount.
- Your benefit limits, including any annual or lifetime caps or other benefit limits.

- Any rules requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the Plan.

- When a claim for benefits must be filed and how the Claims Administrator handles claims and appeals.

Exclusions and Limitations

The Plan limits or excludes payment for certain expenses or events. Read the Benefits Descriptions to learn about these important things:

- When the Plan will not pay for expenses for health care services and supplies.

- Specific types of expenses or events excluded from coverage under the Plan.

TERMINATION OF COVERAGE

As a covered Eligible Employee, your Plan coverage for a benefits program will end on the earliest termination date described in the applicable Benefits Descriptions.

Plan coverage generally ends:

- When you are no longer an Eligible Employee;

- The last date for which you have made a required contribution when due; or

- The date the Plan terminates, if earlier.

You should carefully review the Benefits Description for any benefits program to confirm when coverage will terminate under that specific benefits program.

Plan coverage for your covered Eligible Dependents generally ends at the same time as yours, but may end sooner for any person who loses his or her status as an Eligible Dependent under the Plan.

See the "COBRA Continuation Coverage" and the "Continuation During Military Leave" headings under the **Certain Legal Rights** section for special rules that allow covered Eligible Employees and their covered Eligible Dependents to continue coverage under the Plan in certain situations where coverage would otherwise terminate.

CERTAIN LEGAL RIGHTS

In General

This section gives information about important legal rights under Federal law relating to the Plan. There may be similar information in the Benefits Descriptions. If you would have greater legal rights under a related section of your Benefits Description than we describe in this section, the Benefits Description will control. If a state insurance law applies to your coverage, it may give you greater rights than Federal law provides.

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

- Continue health care coverage for yourself or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents will have to pay for such coverage. Review the "COBRA Continuation Coverage" heading under this section for the rules governing your COBRA continuation coverage rights, if any.

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 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.

Claims and Appeals

The Claims Administrator administers all claims and appeals on behalf of the Plan. For this purpose, the Claims Administrator is a named fiduciary of the Plan under ERISA. The Claims Administrator has the authority, in its discretion, to interpret the terms of the Plan, decide questions of eligibility for coverage or benefits under the Plan and make any related findings of fact. All decisions made by the Claims Administrator are final and binding on all persons covered under the Plan to the full extent of the law.

The Benefits Descriptions tell you when a claim for benefits must be filed, and how the Claims Administrator handles claims and appeals. **Please review the Benefits Description closely for information regarding the claims and appeals processes. Your ability to appeal or bring an action in court with respect to a claim depends on your compliance with the applicable claims and appeals procedure.**

Please note:

- You may not seek review of a denial of any benefit (insured or self-funded) prior to filing a claim for benefits, and

- You may never bring any action in court to enforce a claim for any benefit (insured or self-funded) prior to exhausting all of your rights to administrative review.

Newborns' and Mothers' Health Act

The medical insurance program under the Plan does not limit benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than: (i) 48 hours following a vaginal delivery; or (ii) 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 Plan authorization for prescribing a length of stay in connection with childbirth for up to 48 hours (or 96 hours following a cesarean section). Pregnancy-related hospitalizations other than for childbirth are subject to the Plan's pre-certification or pre-authorization requirements.

Women's Health and Cancer Rights Act Benefits

As required by the Women's Health and Cancer Rights Act of 1998, Plan benefits are payable for covered expenses incurred by a person covered under the medical insurance program under the Plan for mastectomy-related services including: (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema. For more information about mastectomy-related services covered by the medical insurance program under the Plan, contact the applicable Insurer.

COBRA Continuation Coverage - *applicable only to the Medical Insurance Program, the Dental Insurance Program and the Health Care Reimbursement Program*

You and your Eligible Dependents can temporarily continue Plan coverage at group rates (plus a small administrative fee) in certain instances where Plan coverage for group health coverage would otherwise be lost. For this purpose, "group health coverage" includes any prescription drug benefit included with your medical benefits program, as well as any applicable dental or vision benefit. This option is provided as a result of a 1986 Federal law known as the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

The Plan offers no greater COBRA rights than what the COBRA statute requires, and this summary of COBRA rights should be interpreted accordingly. Even if the Benefits Description says you would have greater COBRA rights than we describe below, the rights described below will control (subject to applicable state law).

COBRA rights in addition to those described under this heading may 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 a Participating 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.

Employee Eligibility for Continuation Coverage

If you are covered as an Eligible Employee, you have the right to elect continuation coverage if you lose your group health coverage under the Plan 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

An Eligible Dependent who is covered as the spouse of a covered Eligible Employee has the right to elect continuation coverage if group health coverage under the Plan is lost for any of these reasons:

- Death of the covered Eligible Employee.
- Reduction in the covered Eligible Employee's hours of employment with the Participating Employer.
- Termination of the covered Eligible Employee's employment (including retirement) with the Participating Employer, for reasons other than gross misconduct.
- Divorce or legal separation from the covered Eligible Employee.
- The covered Eligible Employee becomes entitled to Medicare.

Child Eligibility for Continuation Coverage

An Eligible Dependent who is covered as the child of a covered Eligible Employee has the right to elect continuation coverage if group health coverage under the Plan is lost for any of these reasons:

- Death of the covered Eligible Employee.
- Reduction in the covered Eligible Employee's hours of employment with the Participating Employer.
- Termination of the covered Eligible Employee's employment (including retirement) with the Participating Employer, for reasons other than gross misconduct.
- The covered Eligible 'Employee's divorce or legal separation.
- The covered Eligible Employee becomes entitled to Medicare.
- The covered child ceases to be an Eligible Dependent under the Plan.

A child who is an Eligible Dependent born to or placed for adoption with the covered Eligible 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 Plan. If this notice deadline is not met, the notice will be rejected as untimely and the right to COBRA continuation will be lost. The address for this notice is provided in the section titled "How to Notify the Plan of Qualifying Events and Other Events."

The 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's COBRA administrator, Benefit Resources, Inc., 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's COBRA administrator, Benefit Resources, Inc., in writing 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 the 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 (hand-delivered during normal business hours) no later than the 60th day of your election period to the address described below. The election form may allow you to use other means of notice.

Continuation Coverage, Your Choice

If you do not elect continuation coverage, your group health coverage under the Plan will end.

If you elect continuation coverage, you will receive coverage that is the same as the Plan coverage being provided to similarly situated non-COBRA beneficiaries. This means that if the Plan 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, in the case of an Eligible Dependent who is born to or placed for adoption with a qualified beneficiary during a period of continuation coverage, that child is a qualified beneficiary.

Length of Continuation Coverage

Except as provided below, these are the maximum periods of COBRA continuation coverage (measured from the date of the qualifying event):

- For up to 18 months for you and your covered Eligible Dependents if Plan coverage is lost because of your termination of employment or reduction in hours, and up to 29 months if there is a disability extension (see the Disability Extension discussion under this heading).

- For up to 36 months for your covered Eligible Dependents if the loss of Plan coverage is because of your death, divorce or legal separation.

- For up to 36 months for your covered Eligible Dependent who is a child if the child's loss of Plan coverage is because the child is no longer an "Eligible Dependent" under the Plan.

- If you become entitled to Medicare **before** experiencing a qualifying event that is a termination of employment or reduction in hours of employment, the maximum continuation coverage period for your covered Eligible Dependents is for the later of 36 months from the date your Medicare entitlement is effective, or 18 months (29 months if there is a disability extension) from the date of the termination of employment or reduction in hours.

- In the case of an Eligible Dependent born to or placed for adoption with a covered Eligible Employee during a period of continuation coverage, that child's continuation coverage period extends for the remainder of the covered Eligible Employee's continuation coverage period.

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

- The 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. However, other group health coverage in effect **on or before** the date of your COBRA election will not cause you to be ineligible for COBRA coverage.

- You (or a covered Eligible Dependent) first become entitled, after your COBRA election, to Medicare. However, Medicare coverage in effect **on or before** the date of your COBRA election will not cause you to be ineligible for COBRA coverage.

- Any event happens that permits termination of Plan coverage for cause with respect to covered Eligible Employees or their covered Eligible Dependents who have coverage under the Plan 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.

Shorter Maximum Coverage Period for Medical FSA

In addition to the limits described above, a qualified beneficiary may elect to continue coverage under the Health Care Reimbursement Program ("HCRP"), but only if there is a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). If there is a negative account balance (i.e., year-to-date contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the HCRP.

The maximum COBRA period for the HCRP (if there is a positive account balance as of the date of the qualifying event) ends on the last day of the plan year in which the qualifying event occurred. In other words, COBRA coverage under the HCRP may continue only for the remainder of the plan year in which the qualifying event occurred.

Disability Extension

If you (or a covered Eligible Dependent) are disabled (as formally determined by the Social Security Administration) within 60 days of the date you lose your Plan coverage, a disability extension may apply. A disability extension may also be available for an Eligible Dependent child born to or placed for adoption with the covered Eligible Employee during a period of continuation coverage, if the child becomes disabled within 60 days of the date of birth or placement for adoption.

If the disability extension applies, COBRA continuation coverage due to the covered Eligible Employee's reduction in hours or employment termination will be extended from 18 months to 29 months. To be eligible for 29 months of continuation coverage under this disability extension, you must tell the Plan Administrator of the disability before the end of the 18-month COBRA coverage period and within 60 days of the determination of disability by the Social Security Administration. If you tell the Plan Administrator of the disability within this period, the extension applies for the disabled person and other covered family members.

If the disabled person recovers during the disability extension period, the continuation coverage will be terminated on the first day of the month that is more than 30 days after the date the Social Security Administration determines that the person is no longer disabled. Any person who takes advantage of this provision is required to tell the Plan Administrator of the recovery.

Multiple Qualifying Events

If a family member experiences a second qualifying event **after** COBRA continuation coverage begins because of the covered Eligible Employee's reduction in hours or employment termination, the maximum period of coverage is 36 months from the date of the first qualifying event for affected dependents who are qualified beneficiaries.

For example, if a covered Eligible Employee terminates employment (for reasons other than gross misconduct) on December 31, 2013, the termination is a qualifying event giving rise to a maximum coverage that extends for a period of 18 months, to June 30, 2015. If the employee dies after the employee and the employee's spouse and dependent children have elected continuation coverage and on or before June 30, 2015, the spouse and dependent children who are qualified beneficiaries will be able to receive continuation coverage through December 31, 2016.

Interaction with Family and Medical Leave

The start of an FMLA leave of absence (see the "Coverage during Family and Medical Leave" heading below) is not a COBRA qualifying event. A COBRA qualifying event does not occur for an FMLA leave unless the employee does not return to work after the end of FMLA leave.

Considerations for Electing COBRA Coverage

In considering whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed election form before the due date.

COBRA Coverage Cost

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA continuation coverage. The cost to you for COBRA continuation coverage will change from time to time as Plan costs change.

The Trade Act (discussed above) also created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/benefits.cfm.

Continuation Payments

Your first payment for COBRA continuation coverage must be sent (and postmarked) **within 45 days** of the date you first submit a completed COBRA election form. Unless otherwise indicated in the Benefits Descriptions, your payment for COBRA continuation coverage should be sent to location described in your election form.

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.

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 the Plan Administrator will not send you monthly bills for continuation 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 address described below 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.

You may also hand deliver your notice so long as it is actually received by during business hours by the last day of the applicable notice period.

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

Coverage During Family and Medical Leave

Covered Eligible Employees taking an approved leave of absence under a Federal law called the Family and Medical Leave Act of 1993 ("FMLA") may have certain rights to continue Plan benefits if FMLA applies to your Participating Employer at your location. Your Participating Employer will tell you if any approved leave of absence can be available due to FMLA. If your leave of absence is covered by FMLA, your Plan coverage will continue under the same terms and conditions that would have applied had you continued to work, unless you elect otherwise. This means that you must continue to pay the same cost

for coverage that you paid before the leave began. In most cases, you will continue paying in regular installments over the course of your leave. Contact the Plan Administrator to learn about any additional payment options.

If you do not return to active work with the Participating Employer after the end of your FMLA leave, your Plan coverage will terminate. You may then continue coverage only under COBRA, unless an additional option for continuation coverage is available for your coverage. See the "COBRA Continuation Coverage" heading under this section for the COBRA rules. The Benefits Descriptions tell about any additional continuation coverage option that may be available for your coverage.

If your payment for any required contribution during your FMLA leave is more than 30 days late, your coverage will terminate. Prior to a termination for nonpayment, the Plan Administrator will tell you that your payment is late and you will have at least 15 days from that date to make the payment.

If your coverage is terminated during your FMLA leave for any of the reasons above, your Plan election will be reinstated effective as of the date you return to active employment if all of these things are true:

- You return to active employment immediately upon expiration of your FMLA leave.
- You re-enroll for Plan coverage within 30 days of your return.
- You make the required contribution.

Continuation of Coverage for Military Leave

Covered Eligible Employees going into or returning from military service have certain rights to continued group health plan benefits under a Federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are a covered Eligible Employee who becomes absent from employment with the Participating Employer due to military service, the Participating Employer will treat your military leave as an approved unpaid leave of absence as required by USERRA. You will be entitled to all the rights and benefits under the Plan that are available to any other covered Eligible Employee on an approved unpaid leave of absence.

If your leave of absence coverage under the Plan (including any coverage for your Eligible Dependents) ends while you are on military leave, you and your covered Eligible Dependents can elect to continue Plan coverage for:

- 24 months from the beginning of your military service, or
- If shorter, the period of your military service.

If your leave of absence for military service is for 30 days or more, you may be required to pay 102% of the entire cost of your coverage. For military leaves of 30 days or less, the normal employee cost of coverage applies.

If you return to active employment with the Participating Employer following the military leave, your Plan coverage will be immediately reinstated if all of these things are true:

- You gave the Participating Employer notice that you were leaving employment with the Participating Employer for military service.

- You were covered under the Plan on the day before your military leave.
- Your military leave did not exceed 5 years.
- You were released from service under honorable conditions.
- You report back to the Participating Employer in a timely manner or submit a timely application for reemployment following the military service.

Any continuation coverage provided pursuant to USERRA runs at the same time as COBRA continuation coverage. The "COBRA Continuation Coverage" heading under this section tells the rules for COBRA coverage.

Qualified Medical Child Support Order

The Plan complies with certain qualified medical child support orders ("QMCSOs") for group health plan 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 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 Plan Administrator 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).

PLAN ADMINISTRATION

Named Fiduciary

The Plan Administrator is the named fiduciary with respect to the Plan. The Plan Administrator acts through the officers of the Employer authorized for such purpose. In addition, any Insurer of a benefits program is the named fiduciary for purposes of claims administration.

Powers and Responsibility of Plan Administrator

General

The Plan Administrator is vested with all powers and complete discretionary authority to administer the Plan, and is authorized to make such rules and regulations as he may deem necessary or appropriate to carry out the provisions of the Plan. The Plan Administrator or its delegate shall determine in its discretion any questions arising in the administration, interpretation and application of the Plan, including the finding of facts and the making of determinations relating to eligibility and enrollment of Participants. The decision of the Plan Administrator or its delegate shall be final and binding on all persons.

Right to Receive and Release Necessary Information

The Plan Administrator may release or obtain any information necessary for the application, implementation and determination of the Plan or other plans without consent or notice to any person. This information may be released to or obtained from any insurance company, organization, or person. Any individual claiming benefits under the Plan shall release to the Plan Administrator such information as the Plan Administrator determines to be necessary to implement this provision.

Allocations and Delegations of Responsibility

The Employer and the Plan Administrator shall each have the authority to allocate or delegate, from time to time, in writing, all or any part of their responsibilities under the Plan to such person or persons as the Employer or the Plan Administrator, respectively, may deem advisable and, in the same manner, may revoke any such allocation or delegation of responsibility. Such written allocation or delegation shall include the execution or issuance of an insurance contract or administration agreement to the extent of the discretionary duties of the insurer or administrator under such arrangement with respect to the Plan. Any action of such person in the exercise of such allocated or delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Employer or the Plan Administrator. The Employer and the Plan Administrator shall not be liable for any acts or omissions of any delegate. Any delegate shall report periodically to the Employer or Plan Administrator, as applicable, concerning the discharge of the allocated or delegated responsibilities. As authorized by ERISA, to prevent any two parties from being deemed co-fiduciaries with respect to a particular function, the Plan is intended and shall be construed to allocate to each party only those specific powers, duties, responsibilities and obligations as are specifically granted to such party under or pursuant to the Plan.

Plan Information

Employer, Plan Sponsor and Plan Administrator:

Oral Roberts University
7777 S. Lewis Ave.
Tulsa, OK 74171
(918) 495-7874

Other Participating Employer:

University Broadcasting, Inc.
7777 S. Lewis Ave.
Tulsa, OK 74171

Plan Name: Oral Roberts University Group Benefits Plan ("Plan")

Plan Sponsor's Employer Identification Number: 73-0739626

ERISA Plan Number: 501

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: A welfare benefit plan.

Plan Payments: Plan benefits are paid from general assets of the Participating Employers with respect to self-funded benefits and insurance company payments with respect to insured benefits by the following insurers and claims administrators as indicated below (or any successor entity as communicated by the Employer from time to time) for the respective benefits programs.

Medical Insurance Program

This benefits program is self-funded and claims are administered by the company named below.

CommunityCare HMO, Inc.
218 W. 6th Street
Tulsa, OK 74119

The medical insurance program includes multiple coverage options, including one option that includes a health reimbursement account component that is a part of this Plan and is administered by CommunityCare HMO, Inc.

Dental Insurance and Vision Discount Program

This benefits program is self-funded and claims are administered by the company named below.

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004

Health Care Reimbursement Program (HCRP) (This benefits program is governed by the terms of the Employer's cafeteria plan, and is described in the summary plan description for that plan).

This benefits program is self-funded and claims are administered by the company named below.

Benefit Resources, Inc.
4775 E. 91st Street, Suite 100
Tulsa, OK 74137-2805

Basic Life, Voluntary Life, AD&D Insurance Program

This benefits program is insured by the Insurer named below pursuant to the terms of the insurance contract/policy identified below.

Hartford Life and Accident Insurance Company
200 Hopmeadow Street
Simsbury, Connecticut 06089
Contract Number: 873802

Short Term and Long Term Disability Insurance Program

This benefits program is insured by the Insurer named below pursuant to the terms of the insurance contract/policy identified below.

Hartford Life and Accident Insurance Company
200 Hopmeadow Street
Simsbury, Connecticut 06089
Contract Number: 873802

Employee Assistance Program

This benefits program is insured by the Insurer named below.

CommunityCare HMO, Inc.
218 W. 6th Street
8th Floor
Tulsa, OK 74119

Plan Year: The Plan Year is the 12-month period beginning each December 1. (The coverage period for a benefits program may be different than the Plan Year.)

GENERAL PROVISIONS

Right to Terminate or Amend

The Employer has the right, in its discretion, to terminate the Plan at any time without any liability for that action. The Employer has the right, in its discretion, at any time and without notice to modify, alter, or amend any or all of the rules of the Plan or any of the Plan's benefits.

The Employer may also make any changes or amendments to the Plan retroactively that are necessary or appropriate to qualify or maintain the Plan as meeting the requirements of the Internal Revenue Code or ERISA.

If the Employer cancels the Plan or any benefits under the Plan, participation in the canceled benefits terminates on the date of cancellation. No amendment or termination will affect a person's right to any unpaid Plan benefit if the person has satisfied all requirements to receive the benefit prior to the date of the amendment or termination.

No Right to Continued Employment

Participation in the Plan does not give you any right to continued employment. Your responsibility to perform your duties in a satisfactory and workmanlike manner is not lessened by your participation in the Plan. The Plan does not constitute a contract between you (or any other person whether or not employed by the Participating Employer) and your Participating Employer. Nothing in the Plan interferes with your Participating Employer's right to terminate your employment at any time and treat you without regard to the effect such treatment might have upon you as a participant in the Plan.

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.

Severability of Provisions

If any provision of the Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof, and the Plan shall be construed and enforced as if such provision had not been included.

Coordination with Other Benefits

If a particular expense may be reimbursed as an eligible expense under more than one Plan provision or under any other plan maintained by the Employer, the benefit payable under the Plan shall be limited to the excess, if any, of (i) the amount payable under the Plan provision providing the greatest monetary benefit over (ii) the amount payable under all other Plan provisions and by all other plans maintained by the Employer.

Fraudulent Claims

If a person seeking coverage (or someone seeking coverage on behalf of such person): (a) performs an act, practice or omission that constitutes fraud (including but not limited to submission of a fraudulent application for participation or a fraudulent claim for benefits under the Plan); or (b) makes an intentional misrepresentation of material fact, the Plan Administrator may, in accordance with any restrictions imposed by applicable law: (1) cause such individual and all members of his family unit to forfeit all rights to participate in the Plan or otherwise receive benefits under the Plan; and (2) recover any payments made under the Plan with respect to such fraudulent application, fraudulent claim or intentional misrepresentation.

GLOSSARY

Benefits Description. The Benefits Description includes all the documents or materials provided by the Plan Administrator that govern a benefits program under the Plan, even if a document or material is not named "Benefits Description".

Claims Administrator. For insured benefits, the Insurer is the Claims Administrator. For self-funded benefits, the Claims Administrator is the Plan Administrator or its delegate. The Claims Administrator is a "named fiduciary" of the Plan for purposes of ERISA.

Effective Date. The effective date of this Summary is January 1, 2015.

Eligible Dependents. Generally, means your spouse and children who are eligible for coverage under a benefits program included in the Plan. For purposes of the Plan, the term "spouse" means a person to whom you are married, as determined under the laws of the state in which you were married. The applicable Benefits Description will otherwise describe who is an eligible dependent.

Eligible Employee. Means an employee who is eligible for coverage under the Plan. The **Eligibility** section of this Summary describes who is eligible, subject to the provisions of an applicable Benefits Description. A Benefits Description may use the term "Eligible Person" or a similar term.

Employer. Oral Roberts University.

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

Insurer. A company that has entered into an agreement with the Employer to insure the certain benefits available under the Plan. The Benefits Description tells who is the Insurer for your benefits program. There may be different Insurers for each available benefit.

Participating Employer. The Employer and any of its subsidiaries or affiliates that participate in the Plan. As of January 1, 2015, the Employer and University Broadcasting, Inc. are the Participating Employers in the Plan:

Plan. Oral Roberts University Group Benefits Plan, as may be amended from time to time.

Plan Administrator. Oral Roberts University.

Appendix A

Special Rules for Certain Part-Time Employees
Medical Insurance Program Only

This Appendix A describes medical insurance program eligibility rules for employees who are not eligible to participate in the medical insurance program under the "Eligibility" section. These rules do not apply to any other benefits program under the Plan. An employee who becomes eligible to participate in the medical insurance program pursuant to this Appendix A will be considered an "Eligible Employee" for the period that such employee is eligible to participate in the medical insurance program.

- New Employees: If an employee is determined to have been employed on average at least 130 hours per month during the employee's "initial measurement period", such employee will become eligible to participate in the medical insurance program for the "initial stability period" that follows such initial measurement period and the "initial administrative period". Such employee's eligibility to participate for periods after the initial stability period will be subject to the "standard measurement period" rules for ongoing employees, as described below. For purposes of this paragraph:

  - An "initial measurement period" is the 12-month period beginning on the employee's first day of employment with the Participating Employer.

  - An "initial administrative period" is the period from the end of the initial measurement period through the end of the first calendar month beginning on or after the end of the initial measurement period.

  - An "initial stability period" is the period beginning on the first day of the first calendar month beginning after the end of the initial administrative period and ending on the last day of the calendar year following the calendar year in which the initial stability period began.

- Ongoing Employees: If an employee is determined to have been employed on average at least 130 hours per month during a "standard measurement period", the employee will become eligible to participate in the medical insurance program for the "standard stability period" that follows such standard measurement period. An employee who is determined not to have been employed an average of at least 130 hours per month during a standard measurement period will not be eligible to participate in the Plan for the standard stability period that follows such standard measurement period (though an employee who was eligible to participate during an initial stability period will remain eligible for that entire initial stability period). For purposes of this paragraph:

  - A "standard measurement period" will begin on October 15 of a calendar year and end on October 14 of the following calendar year. The first standard measurement period will be October 15, 2013 – October 14, 2014. There will be an "administrative period from October 15 to December 31 during which the Participating Employer will process enrollment activity.

  - A "standard stability period" will begin on January 1 of a calendar year and end on December 31 of such calendar year. The first standard stability period will be January 1, 2015 to December 31, 2015.

- Hours of Service: The determination of hours of service will be made in accordance with guidance issued regarding the determination of "full-time employees" for purposes of Section 4980H of the Internal Revenue Code. For this purpose, until further guidance is issued, an adjunct faculty member will be credited with: (i) 2¼ hours of service per week for each hour of teaching or classroom time (representing a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers) and, separately, (ii) 1 hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform (such as required office hours or required attendance at faculty meetings).

- Changes in Status:

  - If an employee who is not a full-time employee (and thus is not eligible to participate in the medical insurance program) changes status to a full-time employee during a Plan Year, such employee will become eligible to participate in the medical insurance program. To begin coverage, the employee must enroll within 30 days after the date of the status change, with coverage to begin as of the first day of the calendar month following the Plan Administrator's receipt of a properly completed enrollment request. The enrollment may become effective later to the extent that coverage under the medical insurance program would begin later under the terms of the Plan or the Benefits Description.

  - If a full-time employee ceases to be a full-time employee during a Plan Year, the following rules will apply:

    - If such change occurs before the employee has competed at least one standard measurement period, such employee will cease to be eligible to participate in the medical insurance program as of the last day of the month in which the status change occurred.

    - If such change occurs after the employee has completed at least one standard measurement period, such employee will remain eligible for the medical insurance program for the remainder of the current standard stability period if such employee was employed an average of least 130 hours per month during the standard measurement period associated with such standard stability period. Such employee will cease to be eligible to participate in the Plan as of the last day of the month in which the status change occurred if the employee was not employed an average of at least 130 hours per month during the standard measurement period associated with the current standard stability period.

    The employee's eligibility for future stability periods will be determined in accordance with the rules for ongoing employees as described above.

The Plan Administrator shall have the authority to interpret and apply the rules described in this Appendix A in accordance with applicable law, including the statutory, regulatory and other guidance issued regarding the determination of "full-time employees" for purposes of Section 4980H of the Internal Revenue Code.