

**ANTIOCH UNIVERSITY
FLEXIBLE BENEFIT PLAN
PLAN DOCUMENT
EFFECTIVE JANUARY 1, 2011**

**As amended and restated from the original document and any
amendments thereafter**

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE EMPLOYER, ANY PARTICIPATING EMPLOYER, AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

Antioch University Flexible Benefit Plan Plan Document

Table of Contents

Section	
I	Definitions
II	Participation In The Plan
III	Benefits And Benefit Rules
IV	Contributions
V	Administration
VI	Statement of ERISA Rights
VII	Protected Health Information
VIII	Continuation of Coverage
IX	Miscellaneous

PURPOSE

The purpose of the Plan is to allow Employees of Antioch University to choose certain Benefits provided by Antioch University so that Employees may receive Benefits that best meet their individual needs. Antioch University intends that the Plan qualify as a "cafeteria plan" within the meaning of section 125(c) of the Internal Revenue Code of 1986, as amended, and that the Qualified Benefits that an Employee elects to receive under the Plan be eligible for exclusion from the Employee's income for Federal Income Tax purposes. Antioch University may offer a choice among additional benefits that may not constitute Qualified Benefits, but nothing in this Plan shall be construed as offering any taxable benefits except to the extent that Antioch University may otherwise specifically provide.

SECTION I Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

"**Affiliated Employer**" means:

- A. any corporation which is a member of a controlled group of corporations including those within the meaning of section 1563(a) and 414(b) of the Code, determined without regard to sections 1563(a)(4) and (e)(3)(C), including the Employer;
- B. any organization under common control with the Employer within the meaning of section 414(c) of the Code;
- C. any organization which is included with the Employer in an affiliated service group within the meaning of section 414(m) of the Code; or
- D. any other entity required to be aggregated with the Employer pursuant to regulations under section 414(o) of the Code.

"**Benefit Credits**" means the amount set-aside for Benefits under Section III and credited to the Participant's Reimbursement Account(s).

"**Benefits**" means the Qualified Benefits of Antioch University Flexible Benefits Plan available from time to time as described herein, and as set forth in the Benefit Schedules attached hereto.

"**Board**" means the Board of Directors of Antioch University.

"**Change in Status**" means:

- (a) A change in a Participant's legal marital status, including marriage, divorce, legal separation, annulment, or death of the Participant's Spouse.
- (b) An event affecting the number of the Participant's Dependents, including birth, death, adoption, and placement for adoption.
- (c) A change in employment status of the Participant, his Spouse or Dependents, including termination or commencement of employment (as determined under the Code Section 125 regulations); a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; or a change in the employment

status of the Participant, his Spouse or dependent (e.g., hourly to salary, union to non-union, or full-time to part-time), that affects that person's rights under this Plan or an underlying benefit program (e.g., changing from salaried to hourly-paid, union to non-union or part-time from full-time).

- (d) An event that causes a Participant's Dependent to satisfy or ceases to satisfy the eligibility requirements for a particular benefit, such as attaining a specified age or the Dependent's status as a student.
- (e) A change in the residence of the Participant, his Spouse or Dependent.
- (f) Any other events included under Code Section 125, or regulations or other guidance promulgated thereunder relating to changes in family status. The determination of whether there is a Change in Status shall be determined by the Plan Administrator in its sole discretion, consistent with the regulations under Code Section 125.

"Code" means the Internal Revenue Code of 1986, and the same as may be amended from time to time.

"Committee" means the individual who may be appointed by the Plan Administrator to administer the process of claims review for the Plan in accordance with Section V.

"Compensation" means the total wages including salary, overtime and any bonus paid by a Participating Employer for services rendered during the Plan Year.

"Compensation Reduction Agreement" means a voluntary agreement whereby an Employee agrees to reduce his Compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year), for purposes of obtaining the Qualified Benefits offered by the Plan.

"Dependent" means that for the purposes of this Plan, any individual who is a tax dependent of the Participant as defined in Code § 105(b), with the following exception: Any child to whom Code § 105(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the Flexible Benefit Plan will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent".

As a result of a change to the Internal Revenue Code that was part of federal health care reform, a participant in the Medical Reimbursement Account (Health FSA), can be reimbursed for Qualified Medical Expenses incurred by a child through December 31 of the calendar year in which the child turns age 26, regardless of the child's residency, employment, financial dependence, student status, marital status, or status as a tax dependent. The change applies to expenses that are incurred on or after March 30, 2010 by a participant's son, daughter, stepchild, legally adopted child, or eligible foster child.

"Effective Date" means January 1, 2011, as amended and restated.

"Eligible Employee" means any Employee who meets the specific eligibility requirements for the Plan. Full-Time Employees with more than eighteen (18) hours per week for at least nine (9) months of the year are eligible for this Plan.

"Employee" means any person who is an employee of the Employer and regularly scheduled to work for the Employer in an employee-employer relationship. The term Employee does not include any temporary or seasonal worker, independent contractor, or sole proprietor, partner in a partnership or more than 2% shareholder in a subchapter S corporation.

"Employer" means Antioch University and any other business organization which succeeds to its business and elects to continue this Plan and which adopts this Plan with the consent of the Board.

"Enrollment Period" means the period upon becoming an Eligible Employee. In addition, the Plan Administrator has specified other acceptable enrollment periods, which are the month prior to Plan Anniversary and upon becoming an Eligible Employee.

"Entry Date" means the date upon which your participation begins after you have enrolled in the Plan, provided written application for enrollment is submitted within thirty one (31) days from the date the person begins employment.

"ERISA" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"Expense" means any amount paid or incurred by the Employee for Eligible Benefit Expense not otherwise reimbursed under any group plan, the reimbursement of which by the Employer is intended to be excludable from the income of such Participant under various provisions of the Code.

"Highly Compensated Employee" means any Employee defined as such in section 414(q) of the Code.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1997, which may be modified or amended at any time.

"Individual Premium Conversion Account Plan" means the account established in each Participant's name and which is used to record the allocation of Benefit Credits for the expenditure of the Benefit Program(s) elected by a Participant.

"Key Employee" means any Employee defined as such in section 416(i)(1) of the Code.

"Limited Purpose Medical Reimbursement Account" means the Limited Purpose Medical Reimbursement Account will only reimburse qualified dental and/or vision expenses.

"Participant" means any Eligible Employee who has met the conditions for participation set forth in Section II, below.

"Participating Employer" means the Employer and any affiliated Employer, which adopts this Plan with the consent of the Board.

"Plan" means the Antioch University Flexible Benefits Plan described herein and as amended from time to time.

"Plan Year" means January through December. The plan year will run on a calendar year basis.

"Premium Expense" means the expense or premium paid for the cost of Benefits elected by the Participant.

"Prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Qualified Benefits" means each benefit described in section 125(f) of the Code and the regulations promulgated there under.

"Qualified Dental and/or Vision Expenses" means a dental or vision service that is considered to be medically necessary or prescribed by a licensed practitioner is eligible and the cost of which may be reimbursed or may be reimbursable by any other medical benefit plan to the extent available, before benefits of this plan are available for reimbursement. The cost of such eligible dental or vision services must be supported by adequate evidence of the incurring or payment of cost, and submitted to the Employer by the Participant or his legal representative. The determination of the qualification of the dental or vision service and the determination of the completeness of submitted request for reimbursement will rest solely on the Employer or person or persons appointed to review all claims. The Employer's decision in this determination will be final.

"Qualified Medical Services" means the medical services must diagnose, cure, mitigate, treat or prevent disease or affect any structure or function of the body. The medical service must be incurred primarily for the prevention or alleviation of a physical or mental defect or illness.

"Qualified Section 213 Expenses" means a medical service that is considered to be medically necessary or prescribed by a licensed practitioner is eligible and the cost of which may be reimbursed or may be reimbursable by any other medical benefit plan to the extent available, before benefits of this Plan are available for reimbursement. The cost of such eligible medical services must be supported by adequate evidence of the incurring or payment of cost, and submitted to the Employer by the Participant or his legal representative. The determination of the qualification of the medical service and the determination of the completeness of submitted request for reimbursement will rest solely on the Employer or person or persons appointed to review all claims. The Employer's decision in this determination will be final.

"Reimbursement Accounts" means the accounts established as provided under Section III, in the Participant's name and which are used to record the allocation of Benefit Credits and their expenditure (reimbursement) for Qualified Benefits.

"Retirement" means the "non-termination" of active employment with the Employer.

"Spouse" (as used in this Plan) means the person married to a Participant. Marriage is defined as the union of one man and one woman in accordance with laws of a state, and in accordance with the Defense of Marriage Act, (DOMA).

SECTION II

Participation In The Plan

Commencement of Participation. Each Eligible Employee shall be eligible to become a Participant on his Entry Date. The Entry Date for this Plan is the 1st of January for participation due to plan renewal or the 1st of the month for the following newly hired employees. If first employed on the 1st through the 14th of any month the participant becomes effective on the first day of the month following the date of hire. If first employed on the 15th of the month through the end of the month, the participant will become effective on the first of the second month following his or her date of hire.

Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Compensation Reduction Agreement and by providing such data as are reasonably required by the Employer as a condition of such participation. Section IV of this document shall govern the Compensation Reduction Agreement. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

Cessation of Participation. A Participant will cease to be a Participant as of the earlier of:

- A. the date on which the Plan terminates;
- B. the date on which he ceases to be an Eligible Employee; or
- C. the date on which he fails to make a contribution required under the terms of the Plan.
- D. the date on which a Participating Employer terminates its participation in the Plan.

Nothing in this section shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation. Notwithstanding the foregoing, a former Participant who continues to receive Compensation from the Employer shall remain a Participant for all purposes until such Compensation ceases.

Recommencement of Participation. A reemployed former active Participant may make a new election in the Flexible Benefit Plan which is effective during the Plan Year in which he separated from service with the Employer upon satisfying the eligibility requirement set forth in such plan.

FMLA Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

SECTION III

Benefits And Benefit Rules

Benefit Plans.

This Plan contains the Qualified Benefits of: Individual Premium Conversion Plan, Medical Reimbursement Account Plan, Limited Purpose Medical Reimbursement Account Plan & Dependent Care Reimbursement Account Plan.

Individual Premium Conversion Plan

The Individual Premium Conversion Plan included in this Flexible Benefit Plan provides tax-free reimbursement from the Benefit Credits established by the Employer from the Participant's Compensation Reduction account for the costs or premiums charged under various individual insurance policies not sponsored by Antioch University or any other group sponsored plan.

How the Individual Premium Conversion Plan Works

If you have chosen to cover yourself, your spouse and/or your dependents under an individual policy of health care insurance rather than through the Group Benefit Plans sponsored by Antioch University or any other group sponsored plan, you may be reimbursed through the Individual Premium Conversion Plan for the premiums you pay for that insurance. You will need to estimate the amount of premiums you expect to pay during the Plan Year. Premiums for the plan are reimbursement in the year in which they are incurred. Only premiums paid for individual health insurance plans are eligible for reimbursement.

When you are reimbursed for these qualified expenses, your Individual Premium Conversion Account will be debited in the amount of reimbursement, provided there are sufficient benefit credits available. Once you have elected the amount of your compensation reduction you may not add to or change the amount except as explained above as a result of a Change of Status. You may make a new election to change or eliminate the compensation reduction amounts at the beginning of each Plan Year. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

Compensation reduction amounts in the form of Benefit Credits remaining in your Premium Conversion Account after all qualified claims have been filed and paid during a Plan Year cannot be carried forward in any following year, and will be forfeited. It is therefore important that you carefully estimate your potential needs for the entire length of the Plan Year to assure that you have enough credits for your needs, but so as to have no un-used, remaining credits that you will lose. Notwithstanding the foregoing, the maximum amount of reimbursement under the Individual Premium Conversion Account which is part of this Plan will be available at all times throughout the coverage period in accordance with proposed Treasury regulations section 1.125-2(A-7)(b)(2).

The following charges are not eligible for reimbursement under the Individual Premium Conversion Plan. Any premiums paid or payable for any of the following:

- A. A plan of benefits maintained by another employer;
- B. Any insurance policy or benefit plan that has a cash value feature;
- C. An insurance policy or benefit plan in which the premiums are not considered eligible expenses under Internal Revenue Code Section 213.

Medical Reimbursement Account Plan (Health FSA)

There are some expenses you know you will have to pay for in the coming year; for instance, new eyeglasses, medical and dental expenses not reimbursed by the health plan. Normally you would pay for expenses like these with after-tax income. And because taxes reduce the value of your dollars, you would have to earn considerably more than \$100 to pay \$100 of these expenses.

If you are eligible to participate, the Antioch University Flexible Benefit Plan allows you to contribute pretax income to create a special reimbursement account in order to reimburse yourself on a pretax basis for payment of certain medical and other outlined expenses (See Schedule A). It's like getting a discount on these bills since you don't have to earn as much money to pay for them. The money you contribute to the reimbursement accounts by automatic payroll deduction is not subject to federal or Social Security taxes, but depending on your residence, may be subject to state and local income taxes.

How the Medical Reimbursement Account Works

You may establish a reimbursement account for predictable medical expenses, including dental and vision care expenses. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be reimbursed with pretax pay, deposited on a per pay period basis to the medical reimbursement account. The minimum and maximum pretax deferral allowed for the Medical Reimbursement Account during a Plan Year is shown on Schedule A. Once you have completed the Compensation Reduction Agreement for Medical Reimbursement Account, you may file a claim for the aforementioned medical expenses incurred on or after your Entry Date, and during the current Plan Year, that have not been reimbursed under any other Employer's accident or health plan. Generally, the qualified expenses are costs you incurred that exceed any plan deductibles, co-payments, and co-insurance as determined as allowable medical expenses under IRS Code Section 213, and to the limit of your Benefit Credits. The Plan Administrator will inform you of the rules that apply to filing claims.

Under this category are expenses such as non-reimbursable medical expenses covered by any other Employer's accident and health plan. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed practitioner to qualify. Covered expenses *do not include* premiums paid for other health plan coverage, including plans maintained by the employer of a family member, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage.

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs because the tax laws require unused amounts in your reimbursement accounts to be forfeited at the end of each Plan Year.

When you are reimbursed for these qualified expenses, your Medical Reimbursement Account will be debited in the amount of reimbursement, provided there are sufficient benefit credits available. Once you have elected the amount of

your compensation reduction you may not add to or change the amount except as explained above as a result of a Change of Status. You may make a new election to change or eliminate the compensation reduction amounts during the annual open enrollment period prior to the beginning of each Plan Year. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

Compensation reduction amounts in the form of Benefit Credits remaining in your Reimbursement Account after all qualified claims have been filed and paid during a Plan Year cannot be carried forward in any following year, and will be forfeited. It is therefore important that you carefully estimate your potential needs for the entire length of the Plan Year to assure that you have enough credits for your needs, but so as to have no unused, remaining credits that you will lose.

Notwithstanding the foregoing, the maximum amount of reimbursement under the Medical Reimbursement Account which is part of this Plan will be available at all times throughout the coverage period in accordance with proposed Treasury regulations section 1.125-2(A-7)(b)(2).

How the Limited Purpose Medical Reimbursement Account Works

You may establish a limited purpose medical reimbursement account only for predictable dental and vision expenses. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be reimbursed with pretax pay, deposited on a per pay period basis to the limited purpose medical reimbursement account. The minimum and maximum pretax deferral allowed for the Limited Purpose Medical Reimbursement Account during a Plan Year is shown on Schedule C. Once you have completed the Compensation Reduction Agreement for Limited Purpose Medical Reimbursement Account, you may file a claim for the aforementioned dental and/or vision expenses incurred on or after your Entry Date, and during the current Plan Year, that have not been reimbursed under any other Employer's accident or health plan. Generally, the qualified expenses are costs you incurred that exceed any plan deductibles, co-payments, and co-insurance as determined as allowable medical expenses under IRS Code Section 213, and to the limit of your Benefit Credits. The Plan Administrator will inform you of the rules that apply to filing claims.

Under this category are expenses such as non-reimbursable dental and vision expenses covered by any other Employer's accident and health plan. Generally, the expenses covered must be "medically necessary," or prescribed by a licensed practitioner to qualify. Covered expenses *do not include* premiums paid for other health plan coverage, including plans maintained by the employer of a family member, or expenses for non-reconstructive cosmetic surgery; nor do they include expenses for personal mileage.

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs because the tax laws require unused amounts in your reimbursement accounts to be forfeited at the end of each Plan Year.

When you are reimbursed for these qualified expenses, your Limited Purpose Medical Reimbursement Account will be debited in the amount of reimbursement, provided there are sufficient benefit credits available. Once you have elected the amount of your compensation reduction you may not add to or change the amount except as explained above as a result of a Change of Status. You may make a new election to change or eliminate the compensation reduction amounts during the annual open enrollment period prior to the beginning of each Plan Year. The Internal Revenue Code Section 125 states that these balances cannot be combined with any other reimbursement accounts in this or any other Plan, or used for purposes other than for which they are originally intended.

Compensation reduction amounts in the form of Benefit Credits remaining in your Reimbursement Account after all qualified claims have been filed and paid during a Plan Year cannot be carried forward in any following year, and will be forfeited. It is therefore important that you carefully estimate your potential needs for the entire length of the Plan Year to assure that you have enough credits for your needs, but so as to have no unused, remaining credits that you will lose.

Notwithstanding the foregoing, the maximum amount of reimbursement under the Limited Purpose Medical Reimbursement Account which is part of this Plan will be available at all times throughout the coverage period in accordance with proposed Treasury regulations section 1.125-2(A-7)(b)(2).

Dependent Care Reimbursement Account Plan

Provision of Benefits. Benefits under this Plan shall take the form of reimbursement for Dependent Care, as determined by Code Sec.129, by the Employer for Eligible Expenses incurred by a Participant during the Plan Year. A Participant shall be entitled to benefits under this Plan only for Eligible Expenses incurred after becoming a Participant.

Funding. All Benefits of this Plan will be paid by the Employee, based on the Benefit Credits from the Compensation Reduction Agreements provided by the Participants. Contributions to this Plan for the Plan Year will be limited to the amounts determined by the Compensation Reduction Agreements entered into by the Plan Participants for a Plan Year. All contributions by the Participants will be held by the Employer in whatever manner the Employer deems necessary, as credits in the Participant's Account. Contributions may not exceed the maximum contribution shown on Schedule B of this document.

Claims. The Plan Administrator will inform you as to the frequency of claim submission(s). The Claims Administrator will pay the claims as expeditiously as possible, at times determined by the Plan Administrator.

Amount of Reimbursement. A Participant shall be entitled to benefits under this Plan in an amount that does not exceed his Benefit Credits. No Eligible Expense shall be reimbursed to the extent that the expense exceeds such amount. Each payment hereunder shall be a charge to the Participant's Benefit Credits.

Limitations on Reimbursement. The Employer's payment of benefits under this Plan for any Plan Year will be limited to the lesser of (i) the Participant's Eligible Expenses for the year, or (ii) the Participant's Benefit Credits.

Dependent Care Expenses are expenses that are considered to be employment-related expenses under Code 21(b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if applicable), and expenses for incidental household services, if paid for by the Participant to obtain Qualifying Dependent Care Services – provided, however, that this term does not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of the Dependent Care Expense has been reimbursed elsewhere (e.g., because the Spouse's Dependent Care Reimbursement Account imposes maximum benefit limitations), the Employees Dependent Care Reimbursement Account can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Section.

"**Incurred**" means an eligible expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services. (e.g., services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

"**Qualifying Dependent Care Center**" means a facility that provides full-time or part-time care for more than six individuals (other than individuals who reside at the dependent care center) on a regular basis during the Participant's taxable year, and which:

- A. complies with all applicable laws and regulations of the state and town, city or village in which it is located; and
- B. receives a fee, payment or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for a profit)

"**Qualifying Individual**" means:

- A. a tax dependent of the Participant as defined in Code 152 who is under the age of 13 and who is the Participant's qualifying child as defined in Code 152(a)(1);
- B. a tax dependent of the participant as defined in Code 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or
- C. a Participant's Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced parents, a Qualifying Individual who is a child shall, as provided in Code 21 (e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

"**Qualifying Service Provider**" means Services that both:

- A. related to the care of the Qualifying Individual that enable the Participant and their Spouse to remain gainfully employed after the date of participation in the Dependent Care Reimbursement program and during the Period of Coverage; and
- B. are performed
 - (i) in the Participant's home; or
 - (ii) outside the Participant's home for (1) the care of a Participant's qualifying child who is under age 13; or (2) the care of any other Qualifying Individual who regularly spends at least eight (8) hours per day in the Participant's household. In addition, if the expenses are incurred for services provided by a dependent care center.

"Qualifying Dependent Care Services" means the duties performed to enable a Participant or his Spouse to remain gainfully employed and which are related to the care of a Qualifying Individual.

"Exclusions" means Dependent Care Expenses which do not include amounts paid to:

- A. an individual with respect to whom a personal exemption is allowable under Code 151(c) to a Participant or his or her Spouse;
- B. A Participant's Spouse;
- C. A Participant's child (as defined un Code 152(f)(1)) who us under age 19 years of age at the end of the year in which the expenses were incurred; or
- D. A parent of a Participant's under age 13 qualifying child (as defined in Code 152(a)(1)).

Maximum Annual Benefits. A Participant who is married at the close of a Plan Year may not receive reimbursement for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of:

- A. \$5,000 (or \$2,500 in the case of a married Participant filing a federal income tax return separate from his Spouse);
- B. his Compensation for such Plan Year;
- C. the Compensation of his Spouse for such Plan Year;
- D. the amount set forth in Schedule A attached hereto; or
- E. the Benefit Credits allocated to a Participant's account for the Plan Year.

A Participant who is not married at the close of a Plan Year may not receive reimbursement for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of \$5,000 or his Compensation for the Plan Year. Not with-standing the above, the maximum reimbursement paid under this Plan must also be reduced by the amount of any tax-exempt dependent care assistance benefits received by the Participant or his Spouse from any other employer during the Plan Year.

Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Employees as to eligibility to participate, contributions and/or Benefits, and to comply in this respect with the requirements of the Code. If in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such Participants and/or reduce such Plan Contributions and/or Benefits under the Plan, all as shall be necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

Maximum Overall Contributions. No Participant shall be entitled to reduce Compensation by more than the aggregate maximum annual benefit specified in this section III.

Forfeiture of Unused Benefits. A Participant shall receive no reimbursement for Benefit Credits which are elected but unused during a Plan Year, for any reason.

Benefit Rules

Reimbursement accounts. In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible reimbursement accounts.

- Compensation redirection authorized for premium conversion, medical, limited purpose and dependent reimbursement is in effect for the entire year unless the Participant has a change in family status ---such as marriage, divorce, death of a child or Spouse, adoption or birth of a child, termination or commencement of Spouses' employment, the switching from part-time to full-time employment status or the reverse by the participant or his Spouse or taking of an unpaid leave of absence by the participant or his Spouse or change in child care provider which affects the cost of the childcare.
- The Participant enrolled in the reimbursement account must use all the funds in their reimbursement account by the end of the Plan Year or he will forfeit them; the balances cannot be combined, carried over into the next year, or converted to cash. The participant may continue to submit claims up to three (3) months after the Plan Year ends for the prior year's expenses.
- Employees who terminate employment or terminate from the plan during the Plan Year will be given three (3) months from the date of termination in which to submit request for reimbursement for expenses incurred before termination.

Provision of Benefits. The Employer shall provide such Benefits as the Participant has elected under the Plan, in such amounts as do not exceed the amount allocated to the provision of each such Benefit and subject to Employee Benefit Credits. Such Benefits shall be subject to the provisions of any plan, Summary Plan Description, contract, or other arrangement setting forth the further terms and conditions pursuant to which such Benefits are provided, and any condition or restriction imposed by an Employer providing any Benefit.

Revocation and Modification of Elections, and Change of Status.

- (a) Once an Eligible Employee has elected Benefits under the Plan and the Plan Year has begun, he may not amend or revoke his election of Benefits, unless there is a Change in Status or as may otherwise be permitted under this Section III. The revocation of a designation of Benefits and election of new Benefits may be made by an Eligible Employee only if both the revocation of existing designation of Benefits and election of new Benefits are made on account of and consistent with the previously described Change in Status (except for coverage under COBRA as defined in Section VI, or similar state coverage).
- (b) Change in Coverage.
- (1) If benefit coverage under this Plan is significantly curtailed (as determined by the Plan Administrator in its sole discretion) or ceases during a Plan Year, the Participant may revoke his or her election under the Plan with respect to that coverage and may prospectively elect coverage under another plan that provides similar coverage. Coverage under a benefit plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general.
 - (2) If during a Plan Year the Plan adds or eliminates a benefit, an affected Participant may elect a newly-added benefit, or elect another benefit where a benefit option has been eliminated, prospectively on a pretax basis by making corresponding election changes with respect to the benefit option providing similar coverage.
 - (3) A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, former Spouse, or Dependent's employer, if (a) the cafeteria plan or benefit plan in which the Spouse, former Spouse, or Dependent participates permits its participants to make an election change that would be permitted under Treasury regulation Section 1.125-4(b) through (g); or (b) the Participant's plan year period of coverage is different from the plan year period of coverage under the cafeteria plan or benefit plan of the plan in which the Spouse, former Spouse or Dependent participates.
 - (4) If the Participant's share of the premium increases or decreases during a Plan Year by an insignificant amount, then the appropriate benefit elections of the Participant shall be prospectively increased or decreased to reflect such change. If the Participant's share of the premium increases significantly during a Plan Year, then the Participant may either make a corresponding prospective increase in his or her contributions or may revoke his or her election and in lieu thereof, receive coverage under another Plan option which provides similar coverage. Whether an increase or decrease in cost is significant or insignificant shall be determined by the Plan Administrator, on a reasonable and consistent basis, in accordance with prevailing IRS guidance, and based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).
 - (5) Where there is a judgment, decree, or order (including a qualified medical child support order described in ERISA Section 609) ("Order") resulting from a Participant's divorce, annulment, legal separation, or change in custody, (a) a Participant's election under an accident and health plan may be changed to provide coverage for a Dependent who is the Participant's child if the Order requires such coverage, and (b) coverage of the Dependent who is the Participant's child may be revoked or changed if the Order requires someone other than the Participant to provide such coverage.
 - (6) If a Participant, his Spouse or Dependent who is enrolled in an accident or health plan of the employer becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the accident or health coverage of the person becoming entitled to Medicare or Medicaid. If a Participant, Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the health or accident coverage.
 - (7) If a Participant, his Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by Code §9801(f) (i.e., HIPAA), then a Participant may revoke a prior election for coverage under a group health plan and make a new election, provided that the election corresponds with such special enrollment rights.
 - (8) Where the Participant takes leave under the Family and Medical Leave Act of 1993, the provisions of Section III shall apply.

A Participant entitled to make a new election under this Section III must do so within 30 days of the event described above. Any such election shall apply for the balance of the Plan Year in which the election is made unless a subsequent event (described in this Section III) occurs.

Cash Payments. Any cash to be paid to a Participant with respect to any portion of the Benefit Credits (other than as Qualified Benefits) shall be added to his taxable Compensation and shall be paid to him during the Plan Year subject to any applicable wage withholding or similar taxes. Such payments shall not include interest from the date as of which the Benefit Credits were credited on the Participant's behalf to the date of payment. No Benefit under the Plan shall be paid in any manner that defers the receipt of Compensation beyond the last day of the Plan Year.

Reimbursements. Except as otherwise provided in any plan, contract or arrangement established to provide Benefits, reimbursement of Expenses shall be made at such time and in such amounts as shall be determined by the Employer in accordance with Treasury Regulations 1.125-2 Q&A 7(b)(2). The amount credited to the Participant's Reimbursement

Account(s) for any Plan Year shall be used only to reimburse the Participant for Qualified Benefit up to three (3) months following the end of the Plan Year.

Nondiscrimination. Contributions and Benefits under the Plan shall not discriminate in favor of Highly Compensated Employees nor shall the aggregate cost of the Benefits provided to Key Employees exceed 25% of the aggregate of such cost for the Benefits provided to all Employees under the Plan. The Employer may limit or deny any Employee's Compensation Reduction Agreement to the extent necessary to avoid any such discrimination.

Insurance Contracts. Some or all of the Benefits provided under the Plan may, at the discretion of the Employer, be provided by the purchase of insurance contracts issued by one or more insurance companies, or health care service contracts issued by or provided through a health care service provider, qualified health maintenance organization, or preferred provider organization. Any dividends, retroactive rates, or other refunds which may become payable under any insurance or health care service contracts or benefit programs due to actuarial error in rate calculation shall be the property of and retained by the appropriate Participating Employer.

Forfeiture FSA Account Balances; Use-It-or-Lose-It Rule.

(a) **Use-It-or-Lose-It Rule.** If any balance remains in the Participant's Individual Premium Conversion, Medical Reimbursement Account, Limited Purpose Reimbursement Account or Dependent Care Reimbursement account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for qualified expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) **Use of Forfeitures.** All forfeitures under this Plan shall be used as follows:

- (1) to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing FSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Benefit Credits;
- (2) to reduce the cost of administering the FSA Component during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and
- (3) to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any FSA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the expense was incurred shall be forfeited and applied as described above.

Benefit Costs

The cost of each Benefit shall be determined in a uniform manner according to the benefit option cost described on Schedule A, B, C and D attached hereto. Such costs are subject to change, at the discretion of the Employer, for any future Plan Year for current Participants and at any time prior to the commencement of participation for new Participants.

Termination of Employment. If an Eligible Employee separates from service with the Employer during a period in which he is covered under the Plan, the Employer may terminate the remaining portion of Benefits provided by the Plan. A terminated Employee shall be entitled to reimbursement for claims for Qualified Benefits incurred prior to his termination of employment, only if the Employee (or his estate) applies for such reimbursement up to three (3) months from the termination date.

Employee Contributions. To the extent a Participant does not have sufficient Benefit Credits to pay for the Benefits selected, the Employer is authorized to withhold the additional amounts from a Participant's Compensation from the Employer to the extent required to pay for said Benefits. Further, the Employer may require that such withholdings be made on a post-tax basis.

Payment of Contributions While on FMLA Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") and who elects to continue participation under this Plan shall be responsible for making the required contributions under this Plan during the period of the FMLA Leave. The Plan Administrator in its sole discretion, as previously stated in Section II above, shall determine the manner in which such payments are made. If there is more than one choice below, the Participant may make a selection that best fits his needs.

Prepayment: The Participant may prepay the contributions due during the FMLA Leave period. Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law.

Pay-As-You-Go: The contributions due during the FMLA Leave period may be paid based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as COBRA payments are made, under the Employer's existing rules for payment by employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant.

Catch-Up Option: The Employer may advance the contributions on behalf of the Participant, and may recoup such contributions upon the Participant's return to employment. The Catch-Up Option shall be applied in a manner consistent with Prop. Treas. Reg. Sec. 1.125-3. Pre-payments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law.

Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service", as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions under the Plan, during the period during which he or she is in "uniformed service". The Plan Administrator shall determine the manner in which such payments are made. A Participant whose coverage under the group health insurance plan and/or the medical savings account portion of the Plan is terminated on account of his or her being in "uniformed service", and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such group health plan and/or medical savings account, provided that such requirements would not have been imposed if coverage had not been terminated as a result of the "uniformed service".

SECTION IV **Contributions**

Funding. The Benefits provided shall be paid by the Employer; provided, however, that the Employer's payments under the Plan shall be limited to such amounts of Compensation as a Participant elects to forego pursuant to a Compensation Reduction Agreement. If any benefits of this Plan are insured by a third party insurer, those benefits will be paid by the insurer or its nominee, such as a third party administrator.

Execution of Agreements. Approximately 30 days prior to the beginning of the Plan Year, the Administrator shall provide a written election form, which shall include a Compensation Reduction Agreement to each Participant and to each Employee who is expected to become an Eligible Employee by the first day of the first Plan Year, and all subsequent Plan Years. All Compensation Reduction Agreements entered into by Participants in the Plan shall be executed before the close of the Enrollment Period for the Plan Year for which such agreements will be effective or, in the case of Participants who were not eligible to participate in the Plan at the beginning of the Plan Year, before the first day of the pay period after the Entry Date on which they become eligible to participate in the Plan. Each Compensation Reduction Agreement shall remain effective throughout the Plan Year unless revoked or suspended by reason of any Participant's ceasing to be an Eligible Employee.

No Compensation Reduction Agreement may be revoked by any Participant during the Plan Year for which it is effective, except by reason of a family status change described herein. Any Participant who fails to execute appropriate agreements during the Enrollment Period shall be deemed to have not elected to participate in Plan Year's election and will not be eligible for any Reimbursement Account.

Amount of Compensation Reduction. The Compensation reduction amount shall be specified by the Eligible Employee in the Compensation Reduction Agreement. Such Compensation reduction shall not exceed the amount set forth on Schedule A, B, C and D attached hereto. The Compensation reduction amount shall be designated on a per pay basis, as indicated.

Crediting of Compensation Reduction Amounts. All Compensation reduction amounts shall be applied to reduce the Participant's Compensation for each pay period in as nearly equal amounts as the Employer deems practicable, except as the Employer shall otherwise determine. Compensation reduction amounts shall be credited to the Participant's Benefit Credits as of the end of the pay period to which such amount is attributable, provided, however, that no person's Compensation for any pay period shall be reduced by reason of a Compensation Reduction Agreement, nor shall any Benefit Credits be credited by reason of such agreement, if such person is not an Eligible Employee on the date as of which such Compensation is otherwise payable.

SECTION V **Administration**

Administrator. The Employer shall be the Plan Administrator for the purposes of ERISA. The Plan Administrator's Tax ID Number is: 31-0536640. The type of Plan is a Welfare Plan and the type of Administration is Contract Administration.

The Name of this Plan is the Flexible Benefit Plan, established by the Employer, Antioch University, whose address is 150 E South College Street, Yellow Springs, Ohio 45387. The effective date of this Plan is January 1, 2010. The Plan

Administrators telephone number is (937) 769-1375. The Employer shall be the Agent for service of legal process. In addition, service of legal process may be made upon the Plan Administrator

The Employer has appointed MedBen whose address is 1975 Tamarack Rd, P.O. Box 1096, Newark, OH 43058-1096 and whose telephone number is (800) 297-1829 as claims manager/administrator.

Named Fiduciary. The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration, which has been delegated by the Employer, and any references to the Employer shall instead apply to the delegate. However, if the employer assigns any of the Employer's responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Rules of Administration. The Employer shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to themselves.

Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical and other services to carry out the provisions of the Plan. The Employer shall pay the costs of services and other administrative expenses.

Funding Policy. The Employer shall periodically at its discretion review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

Claims Procedure. To receive benefits under the Plan, a Participant must submit written claims for benefits to the Claim Administrator. The Claims Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan, he may submit a written request to the Claims Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Claims Administrator must respond to such a request within a reasonable time. Additionally, the Claims Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating, in a format determined to be understood by the claimant,

- (i) the specific reason or reasons for the denial;
- (ii) a description of any additional material or information necessary for the claimant to perfect the claim; and
- (iii) an explanation of the claim review procedure.

Such notice will be given within 30 days after the claim is received by the Claim Administrator (or within 60 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30 day period). If such notification is not given within such period, the claims will be considered denied as of the last day of such period, and such person may then request a review of his claim.

Substantiation of Claims. The IRS regulations require that an employee furnish a written statement stating that the expense they are requesting reimbursement on has been incurred and they have not been reimbursed nor will they seek reimbursement under the Antioch University Health Benefit Plan or any other Health Plan, Flexible Spending Plan, Health Reimbursement Arrangement Plan, or Health Savings Account Plan. The Participant does not have to prove the services were paid for, they only have to prove the services were incurred during the applicable Plan Year. The participant must provide supporting documentation from an independent third party, which includes the following:

- A bill or receipt (including name of insured, insurance coverage period, insurance carriers name-address, premium amount, and type of coverage) from commercial health insurance carrier;
- A bill or receipt (including date of service, name of patient, provider name-address, amount, and type of service) from a doctor, dentist, or other supplier;
- A prescription receipt (including the date prescription was filled, name of patient, pharmacy name-address, amount, and prescription name) from a pharmacy;
- Explanation of benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by the medical/dental/vision plan(s) under which the employee or any eligible dependents are covered;
- A bill or receipt (including date(s) services were provided, name of dependent, child care provider name-address-phone number, amount, Tax ID number or Social Security number) from a childcare provider;
- Store receipts are acceptable for hearing aid batteries, contact lens solution, support braces, reading glasses and other eligible over the counter items. The receipt must have the following information printed on the receipt: Store name, date of purchase, Product name and amount of product

- To obtain reimbursement for over the counter drugs or medications, a copy of the prescription for the drug or medication must be submitted either prior to or at the time of filing the claim for reimbursement.

Cancelled checks, handwritten receipts, credit/debit card transaction receipts, balance due or previous balance receipts cannot be used to verify an expense.

Claims Appeals. Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, (b) a statement within the referenced Plan provision. If Participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued thereunder. Participant will be provided, free of charge, with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, claimant may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: MedBen SSU Dept, 1975 Tamarack Rd, P.O. Box 1096, Newark OH 43058-1096, Attn: Claims Appeals. If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 30 days after receipt of the appeal. A Participant is entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits. If Participant receives an adverse benefit determination following the final appeal, Participant has the right to bring a civil action under section 502(a) of ERISA.

Nondiscriminatory Operation. All rules, decisions and designations by the Employer, Claim Administrator, and each Committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

Liability of Administrative Personnel. Neither the Employer nor any of its Employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like claims.

SECTION VI **Statement of ERISA Rights**

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

A. Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
3. Receive a copy 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.

B. Continue Group Health Plan Coverage:

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.

C. Prudent Actions by Plan Fiduciaries:

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

D. Enforce Your Rights:

1. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
2. 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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred ten dollars (\$110.00) a day until you received the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of 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.

SECTION VII **Protected Health Information**

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT PLAN PARTICIPANTS MAY BE USED AND DISCLOSED AND HOW PLAN PARTICIPANTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PROTECTED HEALTH INFORMATION means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and which is one (1) of the following:

- A. transmitted by electronic media, including:
 1. the internet;
 2. an extranet;
 3. leased lines;
 4. dial-up lines;
 5. private networks; and
 6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
- B. maintained in any electronic media; or
- C. transmitted or maintained in any other form or medium.

HEALTH INFORMATION means any information, whether oral or recorded in any form or medium that:

- A. is created or received by this Plan, or a Plan designee; and
- B. relates to any of the following:
 1. the past, present or future physical or mental health or condition of an individual;
 2. the provision of health care to an individual; or
 3. the past, present or future payment for the provision of health care to an individual.

SUMMARY HEALTH INFORMATION means information that may be individually identifiable Health Information that:

- A. summarizes the claims history, claims expenses or type of claims experienced by Eligible Employee under this Plan; and
- B. from which the following information has been removed:
 1. names;
 2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;

3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
4. telephone numbers;
5. fax numbers;
6. electronic mail addresses;
7. social security numbers;
8. medical record numbers;
9. Plan identification numbers; or
10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

PRIVACY OF HEALTH INFORMATION. This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued hereunder. Such procedures will be in effect for this Plan for all transactions performed on or after April 14, 2004. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION. Protected Health Information will only be disclosed or used by the Plan under one of (1) the following conditions:

- A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;
- B. for payment of claims submitted to the Plan, or for utilization review activities as described in Article VI, including, but not limited to, the review of any grievances or appeals involved in such activities which are generated by the Participant or his or her authorized representatives;
- C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:
 1. quality assessment and improvement activities;
 2. evaluation of Plan performance;
 3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
 4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 5. business planning and development of the Plan;
 6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
 7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of Protected Health Information is permitted by this Plan.

DISCLOSURES OF HEALTH INFORMATION TO THE EMPLOYER. The Plan Administrator will disclose, or permit the disclosure of, Health Information to the Employer only as described below:

- A. for any of the purposes and under the conditions described herein;
- B. as Summary Health Information, if requested by the Employer for the following purposes:
 1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
 2. modifying, amending or terminating the Plan; or
- C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Employer for the purpose of performing Plan administrative functions;

Prior to any disclosure of Health Information to the Employer, such entity must agree:

- A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;
- B. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Employer; and
- C. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;
- D. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described herein;
- E. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;
- F. that it will make available its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;
- G. that it will, if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and that it will not retain any copies of such information when no longer needed for the

- purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes which make the return or destruction of the information infeasible; and
- H. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:
1. access to Protected Health Information will only be provided to the following categories of Employer employees: *"listing of individuals/classes of individuals employed by or under the control of the Plan Sponsor who receive Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business"*
 2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the Employer performs for the Plan; and
 3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Employer's established employee discipline and termination procedures.

ACCESS OF PARTICIPANTS TO PROTECTED HEALTH INFORMATION. A Participant has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

- A. psychotherapy notes;
- B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or
- C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator a writing signed by the Participant whose information is being requested. The Plan Administrator will notify the Participant, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

AMENDMENT RIGHTS. A Participant has the right to have the Employer amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

- A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;
- B. the information is not currently maintained in any record by the Plan;
- C. the information would not be available for inspection under the reasons cited; or
- D. the information in the Plan's records is accurate and complete.

Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Participant who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Participant, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities which it has knowledge of such entity's receipt of any information which has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial which includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

SECURITY OF PROTECTED HEALTH INFORMATION. The Employer will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the Employer and the Plan to support the requirements of this section. The Employer will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware to the Plan Administrator.

SECTION VIII

Continuation Of Coverage

In General. The following provisions shall apply to Benefits provided to Eligible Employees and their dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

Continuation of Coverage. To the extent required by Section VI above, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or Spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

- A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event or end of plan year whichever comes first;
- B. in the case of a qualified beneficiary disabled during the first 60 days following the covered Employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event or end of plan year whichever comes first;
- C. in the case of a qualifying event which occurs during the 18-months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee's hours are reduced, for the covered dependents, the date which is 36 months after the date that a covered Employee is terminated (except for gross misconduct), or the date that a covered Employee's hours are reduced;
 - (1) for plan years commencing on or prior to June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered Employee and that Employee's subsequent entitlement to Medicare while continuation coverage is in force for the qualified beneficiary, the date which is 36 months after the date of the covered Employee's entitlement to Medicare;
 - (2) for plan years commencing after June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered employee that occurs less than 18 months before the covered employee becomes subject to Medicare, the date which is the close of the 36 month period beginning on the date the covered employee became entitled to Medicare.
- D. in the case of any qualifying event except as described in A., B., C. and D. above, the date which is 36 months after the date of the qualifying event or end of plan year whichever comes first;
- E. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any Employee;
- F. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;
- G. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event will coverage continue longer than the coverage period as set forth in this Section.

Contribution.

- A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer or a Participating Employer in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments.
- B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.
- C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

Notification by Qualified Beneficiary. Each covered Employee or qualified beneficiary must notify the Employer or a Participating Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's Spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within 60 days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph, which occurs after the date of the enactment of the Tax Reform Act of 1986.

Notification to Qualified Beneficiary. The Employer or a Participating Employer shall provide written notice to each covered Employee and Spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

The Employer or a Participating Employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered Employee from the covered Employee's Spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, Antioch University shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies Antioch University of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

Notification of the requirements of this provision to the Spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such Spouse at the time notification is made.

Definitions. The italicized terms used in the text of this Section VI are defined as follows:

"Dependents" means an individual who meets the definition of dependent under the Participating Employer provided health plan covering the Eligible Employee. For the purposes of the Medical Reimbursement Plan, if any, dependents will also include individuals who are dependents within the meaning of section 152(a) of the Code, and as defined in section 1 hereof.

No person shall be considered a dependent of more than one Employee. If both an Employee and an Employee's Spouse are employed by the Employer or a Participating Employer, then their dependent children may be covered by either Spouse, but not by both.

"Election Period" means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

"Full-Time Student" means a dependent child who is attending a state-accredited educational institute on a full-time basis. The dependent will continue to be considered a Full-Time Student under this Plan until the earliest of the following dates:

- A. the date he or she fails to meet any other eligibility requirement listed in the Dependent definition;
- B. the date enrollment as a full-time student ends;
- C. September 1, annually, if enrolled as a Full-Time Student on the last day of the prior spring term and not reenrolled in the fall term on September 1; or
- D. the date of class graduation following completion of high school, under graduate or post graduate study unless the Plan Administrator receive satisfactory confirmation that the Dependent will continue studies as a Full-Time Student.

Once the child ceases to meet the requirements listed above, such child will not thereafter be eligible for coverage as a Dependent under this Plan.

"Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

"Qualified Beneficiary" means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the dependent (as defined in Section 1 hereof) of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee's gross misconduct) or the reduction in hours of the covered Employee's employment, the term "qualified beneficiary" includes the covered Employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who is a covered Employee during the Coverage Period shall also be a Qualified Beneficiary.

"Exception" - the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code section 911(d)(2) and section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a Spouse or

dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

"Qualifying Event" means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

- (i) the death of the covered Employee;
- (ii) the termination (except by reason of such covered Employee's gross misconduct) or reduction in hours of the covered Employee's employment;
- (iii) divorce or legal separation of the covered Employee from such covered Employee's Spouse, as herein defined.
- (iv) the covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
- (v) a dependent child who ceases to be a dependent child under the terms of this Plan.
- (vi) the Employer's filing for Chapter 11 reorganization, as it would affect retiree coverage.

"University/College" means an accredited institution listed in the current publication of accredited institutions of higher education.

SECTION IX **Miscellaneous**

Amendment and Termination. The Employer or its authorized representative may amend or terminate this Plan at any time by action of the Board. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria plan under Section 125 of the Code. No amendment shall deprive any Participant or beneficiary of any Benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

It is the intention of the Employer that should a termination of the Plan or the amendment of this Plan deprive any Participant of a Benefit Credit that exists upon such termination or amendment that the value of the accounts of the Participant exists upon that date would be paid to the Participant in full.

Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

Alienation of Benefits. No Benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

Facility of Payment. If the Employer deems any person incapable of receiving Benefit to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete release of the Employer and shall be deemed full payment of the Benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

Proof of Claim. As a condition of receiving Benefits under the Plan, any person may be required to submit whatever proof the Employer may require either directly to the Employer or to any person delegated by it.

Status of Benefits. The Employer believes that this Plan is in compliance with section 125 of the Code and that it provides certain Benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting Benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those Benefits.

Agent for Service of Legal Process. The Employer named on Page 1 is the Agent for Service of Legal Process. The Plan Administrator Antioch University may also be an agent for service of legal process.

Applicable Law. The Plan shall be construed and enforced according to the laws of the State of Ohio to the extent not pre-empted by any federal law.

Lost Distributions. Any Benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the Participant to whom payment is due, provided, however that such Benefit shall be reinstated if a claim is made by the Participant for the forfeited Benefit.

Source of Payments. The Employer and any Employer contracts purchased or held by the Employer shall be the sole sources of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

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

Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Tax Effects. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether or not payments received by a Participant under the Plan will be treated as includible in gross income for federal or state income tax purposes.

Multiple Functions. Any person or a group of persons may serve in more than one fiduciary capacity with respect to the Plan.

Gender and Form. Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to purposes other than for the exclusive benefit of Plan participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

Prior Year Claims. Claims may be submitted up to three (3) months past the end of the Plan Year or date of Participants termination from the Plan, whichever comes first.

**Antioch University Flexible Benefit Plan
Plan Document**

SCHEDULE A

**Schedules of Benefits
Medical Reimbursement Account**

Pay Period for Annual Payroll Contributions: bi-weekly or monthly

Employee Annual Contribution Limitations:	Minimum	Maximum
Health Care Spending	\$100.00	\$ 4,000.00

Services must be incurred in order to receive reimbursement from your account. Expenses are considered to be incurred the day the service is rendered, not when you are billed, charged or pay for the services. Reimbursements made during a plan year are only made for eligible expenses incurred during that same plan year.

Examples of expenses for which you may be able to receive reimbursement include:

- Medical and Dental expenses not covered under any other plan
- Deductibles, co-payments and co-insurance that you are responsible for under your primary medical, dental or vision plan, or under any other plan
- Prescription drugs and medications (including over the counter drugs or medicines as long as it is prescribed there is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state)
- Eye exams, eyeglasses, contact lenses, and other vision expenses
- Orthodontic expenses
- Hearing exams, hearing aids, other hearing expenses
- Physical therapy (not massage therapy)
- Chiropractics
- Acupuncture
- Psychotherapy

Examples of expenses for which you cannot be reimbursed include:

- Custodial care
- Health Insurance premiums that you or your spouse pays for coverage under another health plan
- Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods
- Health club dues
- Social activities, such as dance lessons
- Bottled water
- Maternity clothes
- Diaper service or diapers
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins taken for general health purposes
- Cosmetic surgery or other similar procedure, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevents or treats illness or disease.

**Antioch University Flexible Benefit Plan
Plan Document**

SCHEDULE B

**Schedule of Benefits
Dependent Care Reimbursement Account**

Pay Period for Annual Payroll Contributions: bi-weekly or monthly

Employee Annual Contribution Limitations	Minimum	Maximum
Dependent Care Spending	\$100.00	\$ 5,000.00*

Services must be incurred in order to receive reimbursement from your account. Expenses are considered to be incurred the day the service is rendered, not when you are billed, charged or pay for the services. Reimbursements made during a plan year are only made for eligible expenses incurred during that same plan year.

- ** A Participant who is married at the close of a Plan Year may not receive reimbursement for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of:
- A. \$5,000 (or \$2,500 in the case of a married Participant filing a federal income tax return separate from his Spouse);
 - B. his Compensation for such Plan Year;
 - C. the Compensation of his Spouse for such Plan Year; or
 - D. the Benefit Credits allocated to a Participant's account for the Plan Year.

A Participant who is not married at the close of a Plan Year may not receive reimbursement for Eligible Expenses incurred by him for the Plan Year in excess of the lesser of \$5,000 or his Compensation for the Plan Year. Not with-standing the above, the maximum reimbursement paid under this Plan must also be reduced by the amount of any tax-exempt dependent care assistance benefits received by the Participant or his Spouse from any other employer during the Plan Year.

**Antioch University Flexible Benefit Plan
Plan Document**

SCHEDULE C

**Schedules of Benefits
Limited Purpose Medical Reimbursement Account**

Pay Period for Annual Payroll Contributions: bi-weekly or monthly

Employee Annual Contribution Limitations:	Minimum	Maximum
Limited Purpose	\$100.00	\$4,000.00

Services must be incurred in order to receive reimbursement from your account. Expenses are considered to be incurred the day the service is rendered, not when you are billed, charged or pay for the services. Reimbursements made during a plan year are only made for eligible expenses incurred during that same plan year.

Examples of expenses for which you may be able to receive reimbursement include:

- Dental and Vision expenses not covered under any other plan
- Deductibles, co-payments and co-insurance that you are responsible for under your primary dental or vision plan, or under any other plan
- Eye exams, eyeglasses, contact lenses, and other vision expenses
- Orthodontic expenses

Examples of expenses for which you cannot be reimbursed include:

- Deductibles, co-payments and co-insurance that you are responsible for under your primary medical plan, or under any other plan
- Prescription drug co-payments, over the counter antacids, cold medications, pain relievers, allergy medications
- Physical therapy (not massage therapy)
- Chiropractics
- Acupuncture
- Psychotherapy
- Custodial care
- Health Insurance premiums that you or your spouse pays for coverage under another health plan
- Costs for sending a child to a special school for benefits the child may receive from the course of study and disciplinary methods
- Health club dues
- Social activities, such as dance lessons
- Bottled water
- Maternity clothes
- Diaper service or diapers
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins taken for general health purposes
- Cosmetic surgery or other similar procedure, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevents or treats illness or disease.

**Antioch University Flexible Benefit Plan
Plan Document**

SCHEDULE D

**Schedule of Benefits
Individual Premium Conversion Account Plan**

Pay Period for Annual Payroll Contributions: bi-weekly or monthly

Employee Annual Contribution Limitations	Minimum	Maximum
Individual Premium Conversion	\$100.00	\$ 3,000.00

Benefit Programs	Coverage Tiers	Employee Contributions
Health Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child	Included
	Employee & Family	Included
Prescription Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child	Included
	Employee & Family	Included
Dental Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child	Included
	Employee & Family	Included
Vision Insurance Plan	Employee Only	Included
	Employee & Spouse	Included
	Employee & Child	Included
	Employee & Family	Included

The Employee contributions necessary to obtain the coverage options set forth in this Schedule will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period. The necessary form is called "Compensation Redirection Agreement." Required Employee contribution amounts will be considered as the maximum elective Employee contributions necessary for participation in each Plan option provided above.

There are no other Employers affiliated with this plan.