WILLIAM JEWELL COLLEGE

MEDICAL REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE

JANUARY 1 2018

TABLE OF CONTENTS

WILLIAM JEWELL COLLEGE

MEDICAL REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

This Summary Plan Description provides, in general terms, the main features of the William Jewell College Flexible Spending Account (the "Plan"), how it can work for you, and how it can benefit you. Under the Plan, you may choose to redirect a portion of your wages to pay for certain benefits for you, your spouse, and your dependents with pre-tax dollars instead of after-tax dollars. This means that you will pay less in taxes each year and have more money to spend, save, and enjoy.

You should read this Summary Plan Description carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a participant. You should direct any questions you have to the Administrator. There is a Plan document on file, which you may review if you desire. **IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENTS, THE PLAN DOCUMENTS WILL CONTROL.**

I. ELIGIBILITY

1. Who is Eligible?

Any full-time or part-time employee of the employer regularly performing services of at least 20 hours per week will be eligible to participate (but temporary or seasonal employees are not eligible).

2. When Can I Enroll in the Plan?

You will become a participant in the Plan: The first day of the month following thirty (30) days of employment. To become a participant, however, you will be required to complete certain enrollment forms.

3. What Must I Do to Enroll in the Plan?

Before you can participate in the Plan, you must complete an enrollment form and authorize the employer to set aside some portion of your salary that you elect for medical reimbursements under the Plan.

4. What Happens if I Terminate Employment?

Upon termination of employment, your participation in the Plan will automatically terminate. You can receive reimbursement for eligible health care expenses incurred prior to termination. You will have 60 days following termination to submit a claim. ANY CLAIMS SUBMITTED AFTER 60 DAYS FOLLOWING TERMINATION WILL NOT BE REIMBURSED.

However, if coverage would otherwise end due to a qualifying event as outlined in the COBRA laws, you and your covered spouse and dependents may be able to continue coverage under the Plan on an after-tax basis, depending on the nature of the event. Your benefits administrator will give you information on how to continue coverage under the Plan, if this is appropriate.

II. OPERATION

1. How Does the Plan Operate?

Before the start of each "Plan Year" as defined below, you will be able to elect to have some of your upcoming salary contributed to the Plan. These contributions will be applied to the reimbursement of eligible medical expenses. The portion of your salary that you elect to contribute is not subject to income tax or income tax withholding. In other words, the Plan allows you to use tax-free dollars to pay for benefits, which you would normally pay for with after-tax dollars.

III. CONTRIBUTIONS

1. How Much of My Salary May I Contribute to the Plan?

Each year, you may elect to have the employer contribute to the Plan on your behalf an amount that may be used for reimbursements of eligible medical expenses. Your employer will establish a minimum amount and a maximum amount (in accordance with federal law). These amounts will be deducted from your salary each pay period on a pro rata basis over the course of the year.

2. How Is My Salary Measured Under the Plan?

Salary under the Plan means the total cash amount that is paid to you each year.

3. What Happens to Contributions That Are Made to the Plan?

Before each Plan Year begins, you will elect the amount that you would like to contribute to the Plan. Then, during each pay period, the contributions will be used to reimburse you for eligible medical expenses that you submit for reimbursement.

4. When Must I Decide What Coverage I Want?

Except as described in question 6 below, you may elect benefits under the Plan only during the "election period."

5. When Is the Election Period for the Plan?

When you first satisfy the Plan's eligibility requirements and elect to become a participant, and for each Plan Year in which you continue to be a participant, the election period will be established by the Administrator and applied uniformly to all participants. It will normally be the thirty (30) day period following your eligibility to participate, if you are a new participant.

6. May I Change My Elections During the Plan Year?

The decision to participate will be binding for the full Plan Year. You may change this election only under the following circumstances:

(a) You may change your participation election prior to the beginning of each new Plan Year. The election you make will be binding for the new Plan Year. The Administrator also will announce any special enrollment periods that may be applicable under certain circumstances.

(b) You may make a new election under the Medical Reimbursement Plan only if you had a "change in status" and the requested election change is consistent with that change in status. The events that constitute a change in status include the following:

(i) Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.

(ii) Events that change your number of dependents, including birth, death, adoption, and placement for adoption. (Note: Gaining or losing a dependent who is not a tax dependent—such as a parent, domestic partner, or child of a domestic partner who is not a dependent as defined under the Internal Revenue Code—will not be considered an allowable event for an election change).

(iii) Events that change your employment status or the employment status of your spouse or dependents that effect your eligibility for benefits including a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in worksite.

(iv) Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age.

(v) A change in your place of residence, the place of residence of your spouse or dependent that effect eligibility for benefits under the plan.

There may be other events which are considered to be a change in status. Also, if there is a change in the premium expense for an insured benefit available under the Plan, we may, if permitted by law, adjust the election you have made for the rest of the Plan Year. Please contact the Administrator for more information on changes in status.

7. Can I Make a New Election if I Terminate Employment and I am Rehired in the Same Plan Year?

If you terminate employment and are **rehired in less than 30 days**, you will re-enter the Plan with the same election you had before you left. The employer must allow the full target amount. In this case, you do not have to pay the missed premiums, but expenses incurred during the time off are not eligible.

8. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. Re-enrollment during the annual open enrollment period for this Plan is required for each calendar year.

9. What is the Impact of the Family and Medical Leave Act?

Notwithstanding any other provision in this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more benefit coverages under the Plan, (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement and (c) permit payment of the participant's share of the cost of benefit coverage during an unpaid leave with after-tax dollars (or discontinue payment of his or her share of the premium during an unpaid FMLA leave period), to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any regulation pertaining thereto. You should consult the Administrator if you have any questions.

10. What is a Qualified Reservist Distribution?

A Qualified Reservist Distribution permits you to take a distribution of the amount you have contributed to the Plan (less reimbursements you have received or distributions previously taken) as of the date you request the distribution. If you are ordered or called to active military duty for 180 days or more you may request a Qualified Reservist Distribution by delivering a copy of such order or call to active duty to the Employer. You must request a Qualified Reservist Distribution on or after the date of the order or call to active duty, and before the last day of the Plan Year (or Grace Period, if applicable) during which the order or call to active duty occurred. A Qualified Reservist Distribution is included in your gross income and wages, and is subject to employment taxes. You may submit expenses incurred after the date a Qualified Reservist Distribution. The amount that may be reimbursed is the amount by which you have elected to reduce your compensation, less the sum of the Qualified Reservist Distribution and the amount of the reimbursements you received as of the date of the Qualified Reservist Distribution.

IV. BENEFITS

1. What Benefits Coverage May I Purchase?

Under the Plan, you may choose to receive your entire salary in cash or use a portion for reimbursement of eligible medical expenses, the details of which are included on the election forms furnished by your employer.

2. What Happens When I Elect to Contribute to the Plan?

By participating in the Plan, you can establish a Medical Expense Reimbursement Account. The Medical Expense Reimbursement Account allows you, if you qualify under the tax law and if you elect to participate, to have a portion of your salary placed in a Medical Expense Reimbursement Account every payday. You can place a minimum of $0 and a maximum of $2650 in your Medical Expense Reimbursement Account per year. You may use that money for medical, dental, and vision care expenses incurred by you, your spouse, or your dependents incurred during the Plan Year or on or before 75 days after the end of Plan Year, provided you are not reimbursed for these expenses by any insurance plan under which any of you may be covered (including health insurance, dental insurance, Medicare, Worker's Compensation, etc.), and provided those expenses are of a deductible nature under the Internal Revenue Code. The amount you set aside in your Medical Expense Reimbursement Account will be tax-free. You will not pay any federal or state income taxes or social security taxes on it. BUT YOU MUST USE IT FOR UNREIMBURSED MEDICAL EXPENSES INCURRED ON OR BEFORE 75 DAYS AFTER THE PLAN YEAR OR YOUR REMAINING BALANCE WILL BE FORFEITED. There is a 30 day run out from the end of the grace period.

3. What Medical Expenses Can Be Reimbursed?

Medical expenses that will not be reimbursed by your own, your spouse's or your dependent's health, dental, or vision care insurance (e.g. the cost of eyeglasses) may be claimed for reimbursement under a Medical Expense Reimbursement Account. A dependent child includes, but is not limited to, your biological child, adopted child, stepchild and foster child who has not attained the age of 27 without regard to his or her student, marital, dependent or residency status.

However, if you participate in a HSA, you can only be reimbursed for out-of-pocket dental, vision or preventive care expenses incurred by you and your dependents*;* however, if allowed as provided on Addendum "A" attached hereto, once you satisfy the deductible for the high deductible health plan, you may be reimbursed for medical expenses incurred by you that qualify under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our medical plan.

Once you have satisfied the deductible if you are an HSA participant and if allowed as provided on Addendum "A" attached hereto, drug costs, including insulin, may be reimbursed.

In general, medical expenses are expenses for the medical care (as defined in Section 213(d) of the Code). Expenses that are not eligible for payment under the Plan include, but are not limited to, cosmetic-related medical services and medications that do not meaningfully promote the proper function of the body or treat an illness or disease, weight loss programs (except

those that are physician required), and health club dues. Effective January 1, 2011, expenses for over-the-counter medicines or drugs for which you do not have a prescription (excluding insulin) are not eligible for reimbursement from your Medical Expense Reimbursement Account. A prescription means a written or electronic order that meets the legal requirements of the state in which the medical expense is incurred, and is issued by an individual who is legally authorized to issue a prescription in that state. Please refer to IRS Publication 502 for a description of the expenses that may be reimbursed under the Plan.

Newborns' and Mothers' Health Protection Act: Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

4. How Do I File a Claim for Reimbursement of Medical Expenses?

In order to seek reimbursement, you must submit a claim with documentation of your unreimbursed medical expenses to the Plan Administrator. The procedure and documentation required by the Plan Administrator are:

First, you must submit your claims under any insurance plan under which the person receiving the medical service is covered - your own, your spouse’s, and/or your dependent’s health, dental, vision care, Medicare, etc. plans. This will result in the insurer sending an Explanation of Benefits (EOB). You may send the EOB as documentation of an unreimbursed out-of-pocket medical expense. Second, for unreimbursed out-of-pocket medical expenses not covered by insurance and not documented by an EOB, you may submit a provider statement of the expenses, including: name of the recipient of the service; date of the service; description of the service; cost of the service; and name, address and tax I.D. number of the provider. You must also fill out a form provided to you by the Plan Administrator.

Effective January 1, 2011, if the unreimbursed out-of-pocket medical expense is for the purchase of an over-the-counter medicine or drug, you must submit a receipt or other document from a third party provider (e.g., grocery store, pharmacy) that identifies the specific over-the-counter medicine or drug purchased and copy of the prescription.

Under certain circumstances, and in accordance with the IRS rules regarding substantiation, the employer may arrange for the use of credit, debit, or store-value cards to pay

for medical expenses. If that occurs, you should follow the instructions for use provided by the Plan Administrator.

The Plan Administrator will process your claim, deduct the money from your account, and send you a check in payment of your claim.

If there is not enough money in your Medical Expense Reimbursement Account at that time during the year to cover the claim you have submitted, the Plan Administrator will pay your claim, up to the total amount you will contribute to the Plan during the Plan Year.

IN ALL CIRCUMSTANCES, YOUR CLAIMS FOR REIMBURSEMENT MUST BE SUBMITTED NO LATER THAN 30 DAYS PAST THE END OF THE PLAN YEAR (OR GRACE PERIOD) IN ORDER TO BE ALLOWED.

5. What is the Impact on My Federal Tax Deduction for Medical Expenses?

Expenses that are reimbursed through the Medical Reimbursement Plan cannot also be used as deductible expenses when filing your personal income taxes. However, the Medical Reimbursement Plan allows you to save taxes on health related expenses, even if the expenses do not exceed the 7.5% of your gross income required to claim them as a deduction on your personal income tax return.

6. What Happens to My Account if I Still Have a Balance at the End of the Year?

The law requires that under no circumstances will you be entitled to a return or refund of the salary reductions which are not used to pay medical expenses. Any amount remaining in your Medical Expense Reimbursement Account after the last day on which you can submit a claim will be forfeited. IN OTHER WORDS, YOU MUST USE THE ENTIRE AMOUNT IN YOUR MEDICAL EXPENSE REIMBURSEMENT ACCOUNT ON OR BEFORE 75 DAYS AFTER THE PLAN YEAR OR YOU LOSE IT. You should probably be conservative regarding the amount by which your salary should be reduced, keeping in mind that over-the-counter drugs obtained without a prescription (excluding insulin) after December 31, 2010 are not reimbursable.

You may submit claims for expenses incurred during the Plan Year and up to 30 days after the end of the Plan Year. Expenses incurred after the end of the Plan Year but before 75 days past the end of the Plan Year will be credited first against any contribution in your Account from the Plan Year.

7. What are the procedures if my plan allows use of a debit card?

If the debit card is offered, Participants may, subject to a procedure established by the Administrator and applied in a uniform and nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of allowable expenses, subject to the following terms:

a. Each Participant issued a card shall certify that such a card shall only be used for allowable expenses. The Participant shall also certify that any allowable expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.
b. Such a card shall be issued in a manner determined by the Plan Administrator and reissued on a periodic basis providing the Participant remains a Participant in the Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant withdraws from the Flexible Spending Account.
c. The dollar amount of coverage available on the card shall be the amount the employee elects during the plan year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in the Adoption Information.
d. The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator.
e. The cards shall only be used for Medical Expense purchases at accepted providers.
f. Such purchases by the cards shall be subject to substantiation by the Administrator or Plan Service Provider, usually by submission of an Explanation of Benefits from the Health Insurance Carrier or a receipt from a merchant or service provider describing the service or product, the date of the purchase and the amount of patient responsibility. Some charges shall be substantiated at the time of charge by the nature of the charge, such as co-payments. Some charges shall be considered substantiated due to their "recurring" nature, in which the expenses match expenses previously approved as to amount, provider, and time period. At point of sale, the service provider or merchant can provide information to the Administrator or Plan Service Provider to substantiate the charge. All charges shall be conditional pending confirmation and substantiation.
g. Expenses must be incurred during the plan year. Incurred is defined as the date services are rendered, not the date the payment was made.
h. If such purchase is later determined by the Administrator or Plan Service Provider not to be a Qualifying Medical Expense, the Administrator or Plan Service Provider, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator or Plan Service Provider shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.
    i. Repayment of the improper amount by the Participant ;
    ii. Claims substitution or offset of future claims until the amount is repaid;
    iii. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law.

V. HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Those Who Are Highly Compensated?

If you are a highly compensated employee or a key employee as defined by IRS, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Federal tax laws provide that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Plan.

Plan experience will dictate whether contribution limitations on "highly compensated" employees or "key employees" will apply. You will be notified of these limitations if you are affected.

VI. ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under this Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Plan Administrator for further details.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

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

2. Claims Procedure.

If for some reason a claim for reimbursement under is denied, formal procedures have been developed so that you (or your beneficiary, if applicable) can appeal the decision. The timing of the initial decision regarding a claim, the period to file an appeal and the period for deciding an appeal are described below.

Decision on the Claim

Unless special circumstances require an extension of time for processing the claim, the Plan Administrator shall send you by mail, postage prepaid, notice of the decision within 30 days after the Plan Administrator receives a properly completed claim form and written proof of loss satisfactory to the Plan Administrator. If an extension is necessary, you shall be given a written notice of the required extension prior to the expiration of the initial 30-day period. The notice shall indicate the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. In no event may the extension exceed 15 days from the end of the initial period. If such an extension is necessary due to your failure to submit necessary information to decide the claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification of Denial

If your claim is denied in whole or in part, you shall be notified of the denial in writing. The notice of denial shall contain the following information:

- the specific reason(s) for the denial;
- a reference to the specific provision(s) in the Plan on which the denial is based;
- a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;
- an explanation of the procedure to appeal the denial, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following the review of a denied claim, and

- an explanation of any internal rule or criteria that was relied upon in denying the claim and that a copy of such rule or criteria will be provided free of charge to the claimant upon request.

Right to Appeal

If your claim for benefits under the Plan has been denied, in whole or in part, you shall have the right to appeal the denial pursuant to the procedure contained herein. You shall also have the right to examine all pertinent documents in preparation of your appeal.

The petition for appeal shall be in writing and shall state your name and address; the fact that you are disputing the denial of a claim; the date of the notice of denial; and the reason(s), in clear and concise terms, for disputing the denial. The appeal shall include any pertinent documentation not already furnished to the Plan Administrator.

The petition for appeal shall be delivered to the Plan Administrator within 180 days after receipt of a notice of denial. The claim shall be reviewed by an appropriate named fiduciary of the Plan who is neither the individual who denied the claim nor the subordinate of such individual. Deference shall not be given to the initial denial of the claim. If an appeal of a denied claim is based on medical judgment, the appropriate named fiduciary shall consult with a health care professional who was not previously consulted in connection with the initial claim (nor a subordinate to such individual) who has appropriate training and experience in the field of medicine involved in the medical judgment. In the event such a health care professional is consulted, he shall be identified to the claimant. To the extent the Plan Administrator is required to furnish copies of documents, such copies shall be free of charge. Upon good cause shown, the Plan Administrator may permit the petition to be amended or supplemented.

Decision on Appeal.

A decision on appeal shall be made by the Plan Administrator within 60 days after receipt of the written petition for appeal. Extensions of time are not permitted with respect to post-service claims. You shall be advised of the determination on appeal in writing, stating

- the specific reason(s) for the decision,
- a specific reference(s) to the provision(s) of the Plan on which the decision is based,
- a statement of your right to receive, upon request and free of charge, reasonable access to and copies of, all documents records and other relevant information,
- a statement of your right to bring a civil action under Section 502(a) of ERISA following the review of a denied claim,
- an explanation of any internal rule or criteria that was relied upon in denying the claim and that a copy of such rule or criteria will be provided free of charge to you upon request and,
- The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to

contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

VII. HIPAA

A federal law, the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), requires that the Plan protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The Plan and your employer, as sponsor of the Plan, will not use or further disclose information that is protected under HIPAA, known as Personal Health Information ("PHI"), except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

As required under HIPAA, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without a written authorization from you, use or disclose PHI for employment-related actions and decisions or in connection with any other employer benefit or employment benefit plan.

Under HIPAA, you have certain rights with respect to your PHI, including the right to review and copy the information, receive an accounting of any disclosures of the information and, under certain circumstances, amend the information. You also have a right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. If you believe your rights under HIPAA have been violated, you can file a complaint with the Plan's Privacy Official who is identified in the privacy notice.

VIII. GENERAL INFORMATION ABOUT THE PLAN

This section contains certain general information which you may need to know about the Plan.

1. General Plan Information

The name of the Plan is William Jewell College Flexible Spending Account.

Your employer has assigned Plan Identifier MEDFSA to your Plan.

The provisions of the Plan, as initially adopted or subsequently amended and restated, as the case may be, are effective on January 1, 2018, which is the Effective Date.

Your Plan's records are maintained on a fiscal period known as the Plan Year. The Plan Year means each period beginning on January 1 of each year and ending on the following December 31. The initial plan year shall begin on the Effective Date and end on the following December 31.

2. Employer Information

Your employer's name, address, and identification number are:

William Jewell College
500 College Hill Campus Box 1017
Liberty, MO 64068-1896

Employer Identification Number (E.I.N.): 44-0545914

3. Plan Administrator Information

The name, title, address, and business telephone number of your Plan's Administrator is:

William Jewell College
500 College Hill Campus Box 1017
Liberty, MO 64068
816.415.5083

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Administrator has retained the services of Phillips Resource Network, Inc. ("PRN") to assist the Administrator in administering the Plan. PRN will also answer any questions you may have about the Plan. PRN's toll free phone number is 877-776-7125.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process (the Plan Administrator) is:

William Jewell College
500 College Hill Campus Box 1017
Liberty, MO 64068

5. Type of Administration

Flexible Spending Account: The type of Administration is Employee administration.

IX. SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. The Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

WILLIAM JEWELL COLLEGE

FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

January 1 2018 – December 31 2018

ADDENDUM "A"

A. Contributions

The Maximum Annual Election for Medical Reimbursement is **$2,650.00.**

B. Claims Submission and Payment

Payouts are to occur on **Friday** of each week during the plan and runout period. Reimbursements are paid weekly and must be submitted by 5:00 pm CT Monday for payout on the following Friday. Claim reimbursements will be made directly to the employee through ACH direct deposit or a check mailed to the Participant's address of record.

Claims can be mailed, faxed or submitted online to PRN at

Phillips Resource Network
PO Box 653
Overland Park, KS 66201-0653

913.261.0083 Fax number

www.phillipsresource.com Participant must login to access online claims entry.
Prns125@phillipsresource.com Scanned claim submissions and questions.

Your plan allows for a Grace Period: You must use your funds on or before 75 days after the plan year. This is an **additional 75 days** to use remaining balances or your balance may be forfeited.

Upon termination of employment, your participation in the Plan will automatically terminate. You can receive reimbursement for eligible health care expenses incurred prior to termination. **You will have 60 days following termination to submit a claim**. Any claims submitted after 60 days following termination will not be reimbursed.

C. Limitation on Reimbursement of Medical Expenses if You Participate in a Health Savings Account

If you participate in a Health Savings Account (an "HSA"), you may only seek reimbursement for those medical expenses checked below:

☑ Medical expenses for dental, vision or preventive care.

☐ Medical expenses in excess of the deductible under our medical plan.