
**CAFETERIA PLAN
FOR EMPLOYEES OF
ROLLINS COLLEGE**

SUMMARY PLAN DESCRIPTION

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TABLE OF CONTENTS

| TOPIC | PAGE |
|---|-------------|
| PART I – General Information about the Cafeteria Plan | 1 |
| I-1. What is the purpose of the Plan? | 1 |
| I-2. When did the Plan take effect? | 1 |
| I-3. Who can participate in the Plan? | 1 |
| I-4. What benefits are offered through the Plan? | 2 |
| I-5. How do I become a Participant? | 2 |
| I-6. What is the annual open enrollment period for the Plan? | 2 |
| I-7. Can I change my election during the Plan Year? | 2 |
| I-8. How do I receive my benefits under the Plan? | 5 |
| I-9. Can I stay in the Plan if I am absent on a family medical leave? | 5 |
| I-10. What if I am absent from work for duty in the uniformed services? | 5 |
| I-11. What if I terminate my employment during the Plan Year? | 6 |
| I-12. Will I have any administrative costs under the Plan? | 6 |
| I-13. How long will the Plan remain in effect? | 6 |
| I-14. Are my benefits taxable? | 6 |
| I-15. What happens if my claim for benefits is denied? | 6 |
| I-16. What is “Continuation Coverage” and how does it work? | 6 |
| PART II – Insurance Premium Benefits | 7 |
| PART III – Cash Benefits | 7 |
| PART IV – ERISA Rights | 8 |
| PART V – Administrative Information | 10 |

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SUMMARY PLAN DESCRIPTION

Rollins College (the “Institution”) is pleased to sponsor an employee benefit program known as the Cafeteria Plan for Employees of Rollins College (the “Plan”). Under federal tax laws, the Plan is known as a “cafeteria plan” because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Institution provides you with the opportunity to use pre-tax dollars to pay for them by executing a tax savings election form. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount you use to pay for the insurance and fringe benefit programs.

This summary describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between them and this booklet, the plan documents will apply.

PART I – General Information about the Cafeteria Plan

Questions & Answers

I-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees to use pre-tax dollars to pay for one or more of the benefits offered through the Plan.

I-2. When did the Plan take effect?

The Plan initially became effective January 1, 1991, and was most recently restated in its entirety effective June 1, 2005.

I-3. Who can participate in the Plan?

Each employee of the Institution (other than an employee on an unpaid leave of absence) who is either a full-time faculty member or a staff member may participate in the Plan, provided that the faculty or staff member is regularly scheduled to work a specified minimum number of hours per year, which varies depending on the type of benefit. For purposes of paying for coverage under the Institution’s health or dental plans, an employee must be regularly scheduled to work at least 1,462 hours per year. For other Plan benefits, an employee must be regularly scheduled to work at least 1,000 hours per year. Notwithstanding the foregoing, anyone who was grandfathered as a participant in the Institution’s health care plan as of January 1, 1989 will be eligible to

participate in this Plan as long as the individual continues to be employed by the Institution, no matter how many hours he or she is scheduled to work.

Those employees who actually participate in the Plan are called "Participants". An employee continues to participate until he or she is no longer employed by the Institution (or is on an unpaid leave of absence), or Continuation Coverage (as described below) is no longer in effect.

I-4. What benefits are offered through the Plan?

The Plan has two types of benefits: (i) various health, cancer, dental, vision and group-term life premium benefits (the "Insurance Benefits") (for details, see Part II); and (ii) taxable cash payments in the form of regular salary.

I-5. How do I become a Participant?

You become a Participant by completing a Tax Savings Election Form (the "Election Form") on which you elect one or more of the benefits available under the Plan, as well as agree to a reduction in your compensation to pay for those benefits so elected. You will have 30 days in which to complete the Election Form after you first become eligible to participate in the Plan. In future years, you will be able to complete a new Election Form on-line during the annual enrollment period, and will be able to confirm or change your choices made for the previous Plan Year. The 12-month period commencing each April 1 is called the "Plan Year" and is the period on which we keep the Plan's records. You will become eligible for each of the Insurance Benefits you wish to elect after you have satisfied all the eligibility requirements for participating in the particular Insurance Benefit. Your actual commencement of participation with respect to any benefit cannot begin until you have completed all enrollment procedures, including completing the on-line Election Form, and complying with any enrollment requirements under any of the Insurance Benefits you have elected.

I-6. What is the annual open enrollment period for the Plan?

The annual open enrollment period for enrolling in the Plan will be a period prior to the beginning of the new Plan Year each April 1. The Plan Administrator will inform all participants of the applicable dates for each annual enrollment period.

I-7. Can I change my election during the Plan Year?

Generally, you cannot change your benefit election during the Plan Year. This means that your decision after first becoming eligible and each year during annual enrollment whether or not to participate in the Plan, or the benefits that you wish to select through the Plan, will apply throughout the Plan Year (although your benefit election will automatically terminate if you are no longer working for the Institution). You may change your elections each year only during open enrollment for the coming Plan Year beginning April 1.

There are important exceptions to the general rule. You may revoke or modify your benefit election, or file a new benefit election after the beginning of the Plan Year, but only if the revocation or change and/or your new benefit election are on account of and consistent with any of the reasons set forth in paragraphs (1) through (8) below:

(1) Special Enrollment Rights. You are entitled to special enrollment rights under Section 9801(f) of the Internal Revenue Code. This would be the case if you, your spouse or your dependent did not enroll in any benefit plan that is a "group health plan" because you had other health plan coverage, and then that coverage was lost. Please ask the Plan Administrator if you have any questions whether these special rights apply to you.

(2) Change in Status. There is a change in status event, as follows:

(A) Legal marital status. An event that changes the your legal marital status, including marriage, death of your spouse, divorce, legal separation and annulment.

(B) Number of dependents. An event that changes the number of your dependents, including birth, death, adoption and placement for adoption.

(C) Employment status. An event that changes the employment status of you, your spouse, or your dependent, including commencement or termination of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, or a change in your eligibility to participate in the Plan.

(D) Dependent satisfies or ceases to satisfy eligibility requirements. An event that causes your dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of you, your spouse, or your dependent.

(3) Court order. A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your child or for a foster child who is your dependent.

(4) Medicare/Medicaid. Entitlement or loss of entitlement to Medicare or Medicaid by you, your spouse or your dependent.

(5) FMLA. Your taking leave under the Family and Medical Leave Act. If you revoke or change your benefit election as a result of your FMLA leave, you

may reinstate your election of group medical benefits when you return from the FMLA leave. However, you may not reinstate a revoked election as to any nonhealth insurance benefits until the next regular enrollment period.

(6) Change of Cost of Coverage. There is a change in the cost of coverage of a benefit, as follows:

(A) If the cost of a benefit offered through the Plan increases or decreases, then if you have elected that benefit, your payroll reductions will automatically be increased or decreased, as the case may be, by the amount of the change in your cost of coverage for that benefit.

(B) However, if the cost of a benefit that you have elected significantly increases or decreases, then you may make a consistent change in your benefit election (for example, commencing coverage for a benefit whose cost has significantly decreased, or reducing or eliminating coverage for a benefit whose cost has significantly increased).

(7) Coverage Changes. You will be allowed to modify your benefit election if there is a significant curtailment of a benefit, a change in coverage under another employer (including a change in coverage under a spouse's employer's plan), or loss of coverage under another group health plan.

(8) Other Events. Any other events that the Plan Administrator determines will permit a change or revocation of your election during a Plan Year under rulings and regulations of the Internal Revenue Service and the United States Treasury Department.

If one of the foregoing events occurs, you must inform the Institution of your new benefit election within 30 days of the occurrence. Failure to do so within the 30-day period will result in your not being able to change your benefit election until the next open enrollment period, or until you have another event that would allow a change in your benefit election.

Any revocation or change in your benefit election, or any new benefit election you may file, will be effective on the first day of the first pay period beginning after the benefit election is filed with the Plan Administrator. Your new benefit election will remain in effect for the remainder of the Plan Year unless you have another event that will allow a further change to your benefit election.

In addition to the foregoing, if you, your spouse, or any dependent becomes eligible for COBRA continuation coverage under the Institution's group health plan as provided in Code Section 4980B or any similar state law, and you continue to participate in this Plan, you may elect to increase payments under this Plan in order to pay for the continuation coverage on a pre-tax basis.

Additionally, the Plan's Administrator may modify your benefit election(s) downward during the Plan Year if you are a highly-compensated officer of the Institution or if you are a member of the "highly paid" group of employees (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

I-8. How do I receive my benefits under the Plan?

Benefits under any of the Insurance Benefits programs must be claimed directly with the insurance company through the use of a debit card, or on claims forms provided by those companies.

I-9. Can I stay in the Plan if I am absent on a family medical leave?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act ("FMLA") for periods totaling 12 weeks during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. Of course, you must pay the premiums for the coverage during your absence using one of the two following methods:

- Prepayment. Under the prepayment option, you may (at your option) increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave.
- Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid with pre-tax dollars as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid and you choose this option, you will have to reimburse the Institution at regular intervals from your after-tax funds for the premiums that come due during the leave.

I-10. What if I am absent from work for duty in the uniformed services?

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your plan participation will be not interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the plan by paying premiums under any of the two premium payment options described in Answer I-9.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only

under the Institution's group major medical insurance plan (as described in Answer I-16) for the 18-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

I-11. What if I terminate my employment during the Plan Year?

If your employment with the Institution is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan, other than as may be permitted under the Continuation Coverage provisions that apply to medical benefits elected under the Plan. (See Answer I-16 for a description of Continuation Coverage.)

I-12. Will I have any administrative costs under the Plan?

No. The Institution is bearing the entire cost of administering the Plan.

I-13. How long will the Plan remain in effect?

Although the Institution expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time.

I-14. Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are not currently taxable to you under present law. However, the Institution cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce differing results. In case of doubt, you should consult your own tax adviser.

I-15. What happens if my claim for benefits is denied?

You will be notified of a denial of a claim for an Insurance Benefit by the insurance company providing such benefit, in accordance with the claims procedures under the insurance policy providing the benefit.

I-16. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your spouse and dependents' right, to continue to be covered under any of the medical insurance benefit plans described in Part II, if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is—

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours below 30 per week;

- your death;
- divorce or legal separation from your spouse;
- your becoming eligible to receive Medicare benefits;
- when a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Institution of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Institution, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverages provided through this Plan at stated premium costs with respect to each health plan in which you are a participant. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

PART II – Insurance Premium Benefits

You will be able to choose to participate in one or more of the following insurance programs by indicating your choice or choices on the Election Form, financing your share of the cost by pre-tax dollars, as described earlier. The benefits available are—

- Hospitalization and medical insurance
- Cancer and Specified Disease insurance
- Dental Insurance
- Vision insurance
- Heart Care Plus insurance
- Voluntary group-term life insurance

For the details regarding eligibility provisions, benefit amounts, and premium schedules, please refer to the plan summary of each, separate insurance plan that is being furnished to you by the Institution.

PART III – Cash Benefits

To the extent you do not elect Insurance Benefits, there will be no reduction of your salary, and the amounts that you could have applied to these benefits will be paid to you as regular, taxable salary.

PART IV – ERISA Rights

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 Institution'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 Employee Benefits Security Administration.

Obtain, upon written request to the Institution, 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 Institution may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Institution 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the 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 benefit under this Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under this Plan 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 Institution 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 Institution. 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 domestic relations order or 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 the Plan, you should contact the Institution. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Institution, 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.

PART V – Administrative Information

Institution

Name: Rollins College
Address: 1000 Holt Avenue-2718
Winter Park, Florida 32789-4499
Telephone number: (407) 646-2353
Federal ID number: 62-0624440

Plan Number

The plan number assigned by the Institution is 504.

Agent for Service of Process

Name: Maria Martinez
Address: 1000 Holt Avenue-2718
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