III. Your Rights as a Participant in the Plan

Employee Retirement Income Security Act of 1974 (ERISA)

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

- **Receive Benefits Plan and Program Information**
  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 Employee Benefits Security Administration.

  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 the updated Summary Plan Description. A Charge may be administered for the copies.

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

- **Continuation of Group Medical and Dental Coverage**
  Continue medical and dental care coverage for you, your 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 Wellesley College Employee Welfare Benefits Plan and the Health Care FSA Reimbursement Plan on the rules governing your COBRA continuation coverage rights.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about the ERISA information provided here or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is listed in your telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also review certain publications about your rights and responsibilities under ERISA by visiting the Employee Benefits Security Administration website: **www.dol.gov/ebsa/** or the Department of Labor website: **www.dol.gov/dol/topic/health-plans/erisa.htm**.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for the Wellesley Employee Welfare Benefits Plan and Health Care Reimbursement Plan participants, ERISA imposes duties upon the people who are responsible for the operation of those Plans. The people who operate those Plans, called "fiduciaries" of those Plans, have a duty to do so prudently in the interest of you and other Plan participants and dependents. 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

- If you request a copy of the 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 that 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 a 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 file suit in a federal court. The court will decide who should pay court costs and 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.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In the event that you stop working at Wellesley College, the Heath Insurance Portability and Accountability Act restricts, in certain instances, the right of your new employer to limit your coverage because of pre-existing conditions, provided that you had medical coverage with Wellesley College.

While HIPAA allows an employer to limit coverage by reason of a pre-existing condition for up to 12 months (18 months for late enrollees), this limit may be reduced in certain circumstances by the period of time during which you were covered under Wellesley's (or any predecessor employer's) medical coverage. For example, if you were covered under one of Wellesley College's medical plans in the Employee Welfare Benefits Plan for more than one year, your new employer cannot limit or exclude coverage for any condition that was covered under Wellesley College's medical program, assuming you did not have a 63-day or longer break in coverage.

In the event that your Wellesley College medical coverage ceases, you are entitled to a Certificate of Prior Health Coverage. This certificate is issued by the appropriate Wellesley College medical insurance carrier not by the College.

Under HIPAA, you have certain rights with respect to your protected health information (PHI) including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable 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.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact Wellesley College's Human Resources Office. If you have questions about the privacy of your health information, please contact the Wellesley College Human Resources Benefits Manager who is the College's designated privacy official. Further HIPAA information can be found at the Department of Labor: **http://www.dol.gov/dol/topic/health-plans/portability.htm**

Your Protected Health Information Under HIPPA

Under HIPPA, your protected health information (PHI), which is health information identifiable directly to you, cannot be used except as necessary for treatment, payment, health plan operations and Plan administration or as otherwise permitted by applicable law. By law, the Plan will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Wellesley College.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

COBRA Medical and Dental Continuation Coverage

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after group medical and dental coverage ends if you were enrolled in such coverage and you experience a qualifying event that causes you to lose group medical and dental coverage. Note that same-sex marriages legally entered in Massachusetts are not recognized under federal law. Federal COBRA continuation provisions therefore do not apply to same-sex spouses.

COBRA requires that most employers sponsoring group medical plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of medical coverage called "continuation coverage" at group rates in certain instances ("qualifying events") where coverage under the employer's medical plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. (Both you and your spouse should take time to read this notice carefully.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

If you are an employee of Wellesley College and enrolled in the medical and/or dental coverage offered by the Wellesley College Employee Welfare Benefits Plan, you will become a qualified beneficiary if you lose your group health coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because any one of the following qualifying events happens:

- Your spouse dies;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse's hours of employment are reduced;
- You become divorced or legally separated from your spouse; or
- Your spouse becomes entitled to Medicare (under Part A, Part B, or both).

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any one of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The child ceases to be eligible for coverage under the Plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan Sponsor and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the Wellesley College Human Resources Office has been notified that one of the following qualifying events has occurred for the employee: the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator of the Wellesley College Human Resources Office within 60 days of the later of the date of the qualifying event or the date on which coverage would be lost because of such an event. You must provide this notice to the Plan Contact listed at the end of this summary along with documentation substantiating the divorce, legal separation or loss of dependent status and the effective date of such event.

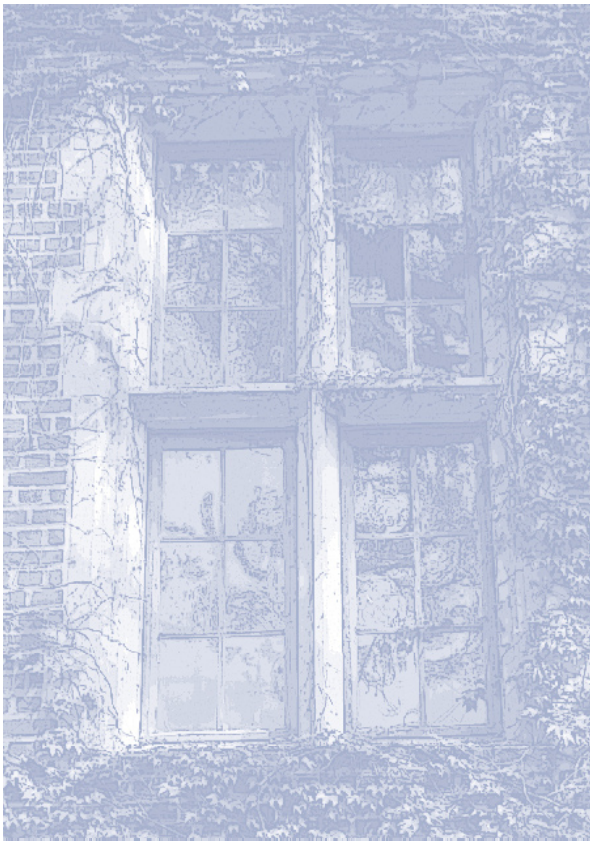
A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and added to the covered employee's COBRA continuation coverage. One must notify the Plan Administrator within 60 days after the birth or placement for adoption occurs to add a child to the employee's coverage. You must also

provide this notice to the Plan Contact listed at the end of this summary along with copies of legal documents substantiating the birth or placement for adoption of the child and the effective date of such an event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Under the law, you have at least 60 days from the date you lost coverage because of one of the events described above to inform the Plan Administrator that you want to elect continuation coverage. If you do not elect continuation coverage, your group medical coverage under the Plan will end as of the date of the qualifying event. If you elect continuation coverage, the Plan Sponsor is required to permit you to elect and purchase coverage that, as of the time coverage is provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.



The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In such a case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months from the date employment terminated or hours were reduced if a second event entitling you to choose continuation coverage (such as death, divorce, legal separation, ceasing to be a dependent child, or Medicare entitlement) occurs within that 18 month period.

The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration (for purposes of Title II, Old Age, Survivors, and Disability Insurance or Title XVI, Supplemental Security Income of the Social Security Act) to have been disabled at any time during the first 60 days of COBRA continuation coverage. This 11 month extension is available to all individuals who are qualified beneficiaries due to a termination in employment or reduction in hours. To benefit from this extension, the qualified beneficiary must notify the Plan of the Social Security Administration's determination within 60 days of such a determination and before the end of the original 18 month period of continuation coverage. The qualified beneficiary must also notify the Employer within 30 days of the date of any final determination by the Social Security Administration that

the individual is no longer disabled.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary must pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to disability, 150 percent) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage.

When and How Must Payment for COBRA Continuation Coverage Be Made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the election form; however, you must make your first payment for continuation coverage not later than 45 days after the date of your election—this is the date the election notice is post-marked if mailed. If you do not make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA administrator at the address, phone number or e-mail address provided at the end of this section to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under COBRA, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace period for periodic payments

Although periodic payments are due on the dates noted above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage

period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Early Termination of COBRA

COBRA provides that your continuation coverage may be terminated before the end of the maximum coverage period for any of the following reasons:

- The Plan Sponsor no longer provides group medical coverage to any of its employees;
- Any required premium for continuation coverage is not paid in full on time;
- A qualified beneficiary becomes covered after electing COBRA continuation coverage under another group medical plan (as an employee or otherwise) that does not impose any pre-existing condition limitation for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage;
- A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group medical plans may impose preexisting condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule (in the third bullet above) with these new limits as follows:

If you become covered by another group medical plan, and that plan contains a preexisting limitation that affects you, your COBRA coverage cannot be terminated. If the other plan's preexisting condition does not, however, apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the Plan Sponsor may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage.

The law also states that at the end of the 18 month, 29 month or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion medical plan if such an individual conversion medical plan is otherwise generally available under the Plan.

Continuation coverage under COBRA is provided subject to the qualified beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible.

COBRA continuation coverage may also be terminated for any reason that the Plan would terminate coverage of a participant or beneficiary enrolled in Wellesley's employee coverage and not receiving continuation coverage (such as fraud).

Keep Wellesley Informed of Address Changes

In order to protect your family's rights, you should keep the Human Resources Office informed of any changes in the addresses of family members. We keep a copy in your records of any notices you send to the Plan administrator.

Plan Contact Information (Plan Administrator)

Benefits Manager
106 Central Street
Wellesley, MA 02481
781-283-2215

If You Have Questions

More detailed information regarding your COBRA continuation coverage rights is available from the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group medical and dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through

Family and Medical Leave Act (FMLA)

All participants in Wellesley College's Employee Welfare Benefits Plan are covered by this act. Under FMLA, you are eligible for at least 12 weeks of unpaid leave for any of the following reasons:

- The birth or adoption of your child or the placement of a child with dependent of you for foster care under the condition that you take the leave within one year of the birth, adoption, or placement
- A serious health condition of your child, spouse, or parent
- Your own serious health condition that prevents you from performing the duties of your job (this condition must require inpatient care or continuing treatment by a health care provider)

If you take a leave of absence under FMLA, you may continue your medical and dental coverage during the leave by continuing to pay the required premiums. If you choose not to continue coverage while on an FMLA leave, you are not reimbursed for any medical and/or dental claims incurred while you are on the FMLA leave. You are eligible to apply for COBRA coverage while on leave. On return from FMLA leave, the medical and/or dental coverage that was discontinued or terminated is reinstated only on reapplication for coverage. If you do not return to work after your FMLA leave ends, you may be eligible to continue coverage under COBRA (further FMLA information can be found at the

Department of Labor: **www.dol.gov/esa/whd/fmla/**).

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under this act, group health care insurers generally do 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).

Plans and insurance issuers may not, under Federal law, require that a provider of services, a doctor or hospital, obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all states of the mastectomy including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your coverage under this Plan. If you would like more information on WHCRA benefits, contact the Plan Administrator at the address and phone number listed in this summary

plan description.

Qualified Medical Child Support Orders (QMCSOs)

As required by ERISA, the Plan recognizes qualified medical child support orders (QMCSOs). A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a Plan participant's group medical coverage and/or dental coverage.

The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the Plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

A QMCSO must be provided to the Plan Sponsor to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Sponsor receives a medical child support order that relates to you, you will be notified and informed of the decision as to whether the order is qualified and provided with a copy of the Plan's QMCSO procedures.

Mental Health Parity and Addiction Equity Act of 2008 (MHPA)

Effective for plan years beginning on and after October 4, 2009, if any group medical coverage feature (1) provides for both medical and surgical mental health or substance use disorder benefits and (2) is not subject to an increased cost exemption (within the meaning of the MHPA):

The group medical coverage feature may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits. The group medical coverage feature may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.

The criteria for medical necessity determinations made under any group medical coverage feature with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the MHPA) to any current or potential participant upon request.

The reason for any denial under the Plan or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the MHPA, be made available by the Plan Administrator to the Participant in accordance with the claims procedures applicable to the group medical coverage feature.

The Plan shall be operated and construed in all respects in compliance with the MHPA.

"Mental health benefits" and "substance use disorder benefits" shall be defined in the contract applicable to the group medical coverage feature, pursuant to applicable state and Federal law, and consistent with generally recognized standards of current medical practice.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under this act, you and your dependents have the right to continue your group health care coverage if you are on a military leave of absence. You and your dependents must pay for this coverage. For more information about filing for coverage under this act, contact the Plan Sponsor. USERRA information can also be found at the Department of Labor: **www.dol.gov/compliance/laws/comp-userra.htm**

Grandfathered Plan Notice

Wellesley College believes its health plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Wellesley College Benefit Manager at 781-283-2215. You may also contact the Employee Benefits Security Administration of the U.S. Department of Labor at 1-866-444-3272 or

www.dol.gov.ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

How to File Claims and Appeals

Claims for Fully Insured Benefits
All claims and appeals of denied claims involving a benefit under the Plan that is fully insured shall be submitted to the applicable insurance carrier, which shall be solely responsible for administering all such claims in accordance with ERISA, including the Department of Labor Regulations thereunder, and state law as applicable. The final determination of the insurance carrier on review shall in all cases be final, and the Plan Sponsor shall not have any authority to overrule any determination of the insurance carrier of a fully insured benefit under the Plan. See the appropriate claims contact information below

Medical and Dental Benefit and Reimbursement Plan Claim Procedure and Appeals
The subscriber certificates provided to you separately at the time of your enrollment in coverage explain how to claim benefits under the Plan as summarized below. If benefits that you believe you are entitled under the Plan or the Reimbursement Plans are not paid, you must make a claim for benefits under the Plan or the Reimbursement Plans in writing to the applicable claims administrator.

Medical Claims

Contact For Medical Claims Administration:	Funding Status:	Group Contract Number:
Harvard Pilgrim Health Care Member Services 1600 Crown Colony Drive Quincy, MA 02169 1-888-333-4742	Fully Insured	HMO #060020
Harvard Pilgrim Health Care Member Services 1600 Crown Colony Drive Quincy, MA 02169 1-888-333-4742	Fully Insured	PPO #069860

Dental Claims

Contact For Dental Claims Administration:	Funding Status:	Group Contract Number:
Delta Dental of Massachusetts Claims Department P.O. Box 9695 Boston, MA 02114 1-800-872-0500	Fully Insured	Delta Premier #7816
Delta Dental of Massachusetts Claims Department P.O. Box 9695 Boston, MA 02114 1-800-327-6277	Fully Insured	DeltaCare #7816

Long Term Disability Claim Review

Contact For Disability Claim Review:	Funding Status:	Policy Number:
Standard Insurance Company Claims Department 900 SW Fifth Avenue Portland, Oregon 97204 503-321-7000	Fully Insured	137951-D

Short Term Disability Claim Review

Contact For Disability Claim Review:	Funding Status:	Policy Number:
Standard Insurance Company Claims Department 900 SW Fifth Avenue Portland, Oregon 97204 503-321-7000	Fully Insured	137951-A

Life Insurance Claim Review

Contact For Life Insurance Claim Review:	Funding Status:	Policy Number:
Standard Insurance Company Claims Department 900 SW Fifth Avenue Portland, Oregon 97204 503-321-7000	Fully Insured	137951-E

Health Care and Dependent Care FSA Claim Review

Contact For FSA Claim Review:	Funding Status:	Policy Number:
Crosby Benefit Systems, Inc. P.O. Box 929125 Needham, MA 02492 1-866-9189711	Self Insured	N/A

Welfare Benefits Plan Administration

Authority of Plan Administrator

The Plan Administrator has complete discretionary authority with regard to the operation, administration and interpretation of the Plan and the Health Care Reimbursement Plan, and any determination by the Plan Administrator relating to the Plan and the Health Care Reimbursement Plan shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. The Plan Administrator may also delegate any of its responsibilities under the Plan and the Health Care Reimbursement Plan to any other person or entity.

Any insurance carrier from which benefits are purchased has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy.

Plan Administration

All benefits under the Plan and the Reimbursement Plans are administered by the insurance carriers from which the benefits are purchased or, in the case of certain self-funded benefits, by a third-party administrator. The name of each carrier or vendor is set out in the ***How to File Claims and Appeals*** section of this SPD. Unless otherwise indicated, all benefits furnished under the Plan are provided under the insurance policies, administrative contracts and/or subscriber certificates of the appropriate carrier or vendor identified in ***How to File Claims and Appeals***, and they provide all necessary administrative services. Please note that the Dependent Care Reimbursement Plan, though mentioned here for administrative purposes, is not subject to ERISA.

Plan Amendment or Termination

The Plan Sponsor hopes to continue the Plan and the Reimbursement Plans indefinitely, but they may be changed or discontinued by the Plan Sponsor with respect to all or any class of employees (to the extent permitted applicable by law) at any time and for any reason without notice. Any amendment or termination shall be effected by a written instrument signed by an officer of the Plan Sponsor or his or her authorized delegate. No vested rights of any nature are provided under the Plan or the Reimbursement Plans.

Additional Plan Information

Name of Plans:	*Wellesley College Employee Welfare Benefits Plan* (the "Plan") Wellesley College Health Care Reimbursement Plan
Plan Sponsor:	*Wellesley College* 106 Central Street Wellesley, MA 02481 781-283-3202
Plan Administrator:	The Plan Sponsor is also the Plan Administrator. The Plan Administrator's address and telephone number is the same as that of the Plan Sponsor listed above.
Agent for Service of Legal Process:	The Plan Administrator (as listed above)

Plan Sponsor's EIN:	04-2103637
Plan Numbers:	502 (the Plan) 514 (the Health Care Reimbursement Plan)
Types of Plans:	The Plan is a health and welfare plan providing medical and prescription drug, dental and life insurance, short term disability and long term disability coverage, long term care insurance and an employee assistance plan as described in the corresponding Benefits Summaries and Subscriber Certificates. The Health Care Reimbursement Plan is a health and welfare plan that provides health care flexible spending account deferrals as described in the corresponding Benefits Summaries and Subscriber Certificates. The Dependent Care Reimbursement Plan is a health and welfare plan that provides dependent care flexible spending account deferrals, as described in the corresponding Benefits Summaries and Subscriber Certificates.
Sources of Plan Contributions:	The Plan: The medical and dental coverage requires joint contributions from participating employees and the Plan Sponsor. The Plan Sponsor determines the amount participating employees must contribute. Employees pay Contributory Life Insurance, Spouse Life Insurance and health and dependent care FSA deferrals without contributions from the Plan Sponsor. Wellesley College Health Care Reimbursement Plan and Dependent Care Reimbursement Plan: Employees pay health care and dependent care FSA deferrals without contributions from the Plan Sponsor.
Plan Year:	The plan year is the 12 month period of January 1 to December 31.