

SUMMARY PLAN DESCRIPTION

for the

FLEXIBLE BENEFITS PLAN

For The Employees of

GEORGE FOX UNIVERSITY

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SUMMARY

**GEORGE FOX UNIVERSITY
FLEXIBLE BENEFITS PLAN**

INTRODUCTION

We have amended the "flexible benefits plan" that we previously established for you and other eligible employees. Under this program, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this summary plan description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the Plan document will control. Also, if there is a conflict between an insurance contract and either the plan document or this summary plan description, the insurance contract will control.

**I
ELIGIBILITY**

1. When Can I Become a Participant in the Plan?

Before you become a member or a "Participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the "eligibility requirements." After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Health Care Reimbursement Plan or Dependent Care Assistance Program.

2. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan as of your date of employment with us. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When Is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month coinciding with or following the date you met the eligibility requirements.

4. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are part-time. A part-time employee is someone who works, or is expected to work, less than 20 hours a week.

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

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless during the "election period" you elect not to participate in this Plan.

II OPERATION

1. How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

III CONTRIBUTIONS

1. How Much of My Pay May the Employer Redirect?

Each year, we will automatically contribute on your behalf enough of your compensation to pay for the coverage provided unless you elect not to receive any or all of such coverage. These amounts will be deducted from your pay over the course of the year.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the non-insured benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When Must I Decide Which Accounts I Want to Use?

You are required by Federal law to decide before the Plan Year begins, during the "election period." You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance unless you elect, during the "election period," not to participate in the Plan.

4. When Is the "Election Period" for Our Plan?

Your election period will start on the date you first meet the "eligibility requirements" and end 30 days after your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period is established by the Administrator and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Administrator will inform you each year about the election period. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

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

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent.

In addition, if you are participating in the Dependent Care Assistance Program, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar

coverage. If you are not a Participant, you may elect to join the Plan. There are also certain situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement Plan, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Assistance Program if the cost change is imposed by a dependent care provider who is your relative.

6. 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. If you do not make new elections during the "election period" before a new Plan Year begins, you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

IV BENEFITS

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Care Reimbursement Plan:

The Health Care Reimbursement Plan enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan and save taxes at the same time. The Plan allows you to be reimbursed by the Employer for out-of-pocket medical, dental and/or vision expenses incurred by you and your dependents. In addition, you may claim reimbursement for your drug costs, including "over-the-counter" drugs. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. A list of covered expenses is available from the Administrator.

The most that you can contribute to your Health Care Reimbursement Plan each Plan Year is \$5,000. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses, such as co-pays, deductibles, medical equipment and drug costs. The Administrator will provide you with further details. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

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).

Dependent Care Assistance Account:

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws.
- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you.

Premium Expense Account:

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our self-funded medical plan.
- Dental insurance premiums.
- Cancer insurance premiums.
- Vision insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any contracts providing benefits described above. Also, your coverage will end when you leave employment, are no longer eligible under the terms of any coverage, or when coverage terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

V BENEFIT PAYMENTS

1. When Will I Receive Payments From My Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. The provisions of the insurance contracts will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the Account to cover your request.

2. What Happens If I Don't Spend All Plan Contributions?

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Care Reimbursement Plan. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Reimbursement Plan, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and

are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Care Reimbursement Plan are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. 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 your Health Care Reimbursement 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 Administrator for further details.

5. What Happens If I Terminate Employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

-- You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

-- You will still be able to request reimbursement for qualifying dependent care expenses from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit all claims within 90 days of termination of employment.

-- Your participation in the Health Care Reimbursement Plan will cease, and no further salary redirection contributions will be contributed on your behalf. However, you will be able to submit claims for health care expenses incurred prior to your date of termination. You must submit all claims within 90 days of termination of employment.

For health benefit coverage and Health Care Reimbursement Plan coverage on termination of employment, please see the Article entitled "CONTINUATION COVERAGE RIGHTS UNDER COBRA."

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI

HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a "highly compensated employee" or a "key employee."

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state 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 our 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.

VII PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

George Fox University Flexible Benefits Plan is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your amended Plan become effective on April 1, 2005. Your Plan was originally effective on February 1, 1990.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on April 1 and ends on March 31.

2. Employer Information

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

George Fox University
414 North Meridian Street #6108
Newberg, Oregon 97132
93-0386839

3. Plan Administrator Information

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

George Fox University
414 North Meridian Street #6108
Newberg, Oregon 97132
(503) 554-2183

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 our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

George Fox University
414 North Meridian Street #6108
Newberg, Oregon 97132

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Allegiance Benefit Plan Management, Inc.
P.O. Box 4346
Missoula, Montana 59806

**IX
ADDITIONAL PLAN INFORMATION**

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, including insurance contracts, 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.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

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 benefit or exercising your rights under ERISA.

If your claim for a 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.

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.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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.

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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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 Process

You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year. However, if you terminate employment during the Plan

Year, you must submit your claims within 90 days after your termination of employment. Any claims submitted after that time will not be considered. Claims for benefits that are insured or self-funded will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If we fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Care Reimbursement Plan, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (a) The specific reason or reasons for the denial.
- (b) Reference to the specific Plan provisions on which the denial was based.
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review.
- (e) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(f) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (a) was relied upon in making the claim determination;
- (b) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

3. Qualified Medical Child Support Order

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

X CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under health benefits under this Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This

notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA. While the Plan itself is not a group health plan, it does provide health benefits. Whenever "Plan" is used in this section, it means any of the health benefits under this Plan including the Health Care Reimbursement Plan.

1. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

2. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

3. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (a) The death of a covered Employee.
- (b) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (c) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (d) A covered Employee's enrollment in any part of the Medicare program.
- (e) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

4. What is the Procedure for Obtaining COBRA Continuation Coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the

Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

5. What is the Election Period and How Long Must It Last?

The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

6. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (a) the end of employment or reduction of hours of employment,
- (b) death of the employee,
- (c) commencement of a proceeding in bankruptcy with respect to the employer, or
- (d) enrollment of the employee in any part of Medicare,

IMPORTANT:

For the 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 or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan

Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

George Fox University
414 North Meridian Street #6108
Newberg, Oregon 97132

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

7. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

8. When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (a) The last day of the applicable maximum coverage period.
- (b) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (c) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (e) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (f) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (1) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

9. What Are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the

Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(1) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(2) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

10. Under What Circumstances Can the Maximum Coverage Period Be Expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee.

11. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee.

12. Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified

Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

13. Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

14. What is Timely Payment for payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

15. Must a Qualified Beneficiary be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

16. How is My Participation in the Health Care Reimbursement Plan Affected?

You can elect to continue your participation in the Health Care Reimbursement Plan for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Reimbursement Plan if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Care Reimbursement Plan. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also

charge you an extra amount (as explained above for other health benefits) to provide this benefit.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

XI 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. Our flexible benefits 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.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**HIPAA PRIVACY NOTICE AND PRACTICES
EFFECTIVE APRIL 14, 2004**

This medical reimbursement flexible spending plan is a Covered Entity under the HIPAA privacy rules. As a Covered Entity, the Plan is required by law to maintain the privacy of protected health information and to provide individuals with this Notice of the Plan's privacy policy and its legal duties and practices with respect to protected health information. This privacy policy will explain how the Plan may use and disclose protected health information, a Covered Person's right of access to his or her protected health information, a Covered Person's right to amend or correct information in his or her Designated Record Set, the type of information the Plan may collect, and what information the Plan may disclose and under what circumstances. Any Covered Person who has agreed to receive this Notice electronically may obtain a paper copy of the Notice upon request to the Plan Administrator.

What is Protected Health Information (PHI)?

Under the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Protected Health Information, or PHI, is health information, including demographic information collected from an individual that:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - (a) That identifies the individual; or
 - (b) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected health information cannot be used or disclosed without the Covered Person's written permission except in certain specified circumstances stated in the HIPAA privacy regulations and described in this Notice.

What are the Plan's Responsibilities Concerning PHI?

The Plan is required by law to maintain the privacy of PHI and maintains a privacy policy and safeguards for carrying out its legal duties concerning PHI. The Plan reserves the right to change the terms of its privacy policy and notice; however, the Plan is required to provide all affected individuals with timely notice, in advance, of any material changes to its privacy policy. The Plan is required to abide by the terms of the notice currently in effect until a revised notice has been provided. As long as the Plan provides coverage under this medical reimbursement flexible spending plan, and as required by law, the Plan will notify Covered Persons of any changes to the Plan's privacy policy. If the Covered Person's coverage ends, the Plan will continue to limit disclosure of nonpublic personal information according to the Plan's stated privacy policy and consistent with applicable law.

The Plan maintains procedural, electronic, and physical safeguards that comply with applicable federal and state regulations to protect PHI. Procedural safeguards include providing only the minimum necessary PHI and limiting access to PHI to individuals with a legitimate need to know for healthcare operations purposes. Electronic safeguards include electronic claims submission, secured storage and retrieval of electronic information, limiting the number of individuals with access to claims and recording all telephone conversations concerning claims and benefits. Physical safeguards include storage of original documents in a secure, locked cold storage for a period of not less than six (6) years and subsequently shredded or returned to the Plan Administrator. Discarded materials are placed in a secured location until they are shredded or recycled.

The Plan conducts periodic meetings with vendors to share privacy concerns, and to review vendor procedures and security issues. Contracted service providers and other entities with whom the Plan must exchange information to conduct business are required to sign a Business Associate Agreement, as defined by HIPAA, through which that entity must agree to maintain the privacy of PHI according to the requirements of applicable privacy laws, this privacy policy and the contract claims payor's privacy practices and procedures.

To Whom and Under What Circumstances Will the Plan Use or Disclose PHI?

The Plan will not disclose any PHI about Covered Persons or former Covered Persons to anyone, except as described in this Notice and as permitted by law. The Plan will only disclose PHI:

- Without a signed written authorization to the Covered Person to whom the PHI pertains (or to a minor child's parent or guardian, if applicable);
- Without a signed written authorization as required for healthcare operations purposes. The Plan is permitted to disclose PHI, without an additional authorization, for healthcare operations purposes. A Healthcare Operations@ includes, but is not necessarily limited to, any of the following activities of the Plan to the extent that the activities are related to covered functions: claims payment, quality assessment; case management; care coordination; contacting of health care providers and patients with information about treatment alternatives; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; health plan performance; accreditation, certification licensing, or credentialing activities; underwriting; premium rating; and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits; ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance); conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and other business management and general administrative activities of the Plan as allowed by law.
- To an individual who provides the Plan with a written authorization signed by the Covered Person to whom the PHI pertains;
- As required by state or federal law, regulation or order of a court with jurisdiction.

Any other uses and disclosures not specifically described above will be made only with the Covered Person's (or the Covered Person's guardian's, if a minor) written authorization. This signed authorization will remain in effect until affirmatively revoked by the Covered Person in writing. A Covered Person may revoke his or her written authorization at any time, as provided by Sec. 164.508(b)(5), by sending written notice to the contract claims payor, except that the authorization cannot be revoked retroactively after action has taken place, such as releasing information in reliance on the authorization. The Plan will not have violated HIPAA's privacy requirements for disclosures made based on a valid authorization on file with the Plan prior to receipt of written revocation.

NOTE: If a use or disclosure for any purpose described in the paragraphs above is prohibited or materially limited by other applicable federal or state law, including state privacy law, the Plan will comply with the use or disclosure requirements of the most stringent applicable law.

When, and Under What Circumstances, Will the Plan Sponsor Have Access to PHI?

The Plan may disclose PHI to the Plan Sponsor under certain limited circumstances relative to the Plan's healthcare operations. The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the regulations by incorporation of the following provisions. With regard to PHI disclosed to the Plan Sponsor, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law;

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;
6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;
7. Make available the information required to provide an accounting of disclosures as required by the regulations;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or employees designated by the Plan Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist Covered Persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

What Information Makes Up the Designated Record Set?

The Designated Record Set means:

1. A group of records maintained by or for a Covered Entity that is:
 - (a) The medical records and billing records about individuals maintained by or for a covered health care provider;
 - (b) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
 - (c) Used, in whole or in part, by or for the Covered Entity to make decisions about individuals.
2. For purposes of this paragraph, the term "record" means any item, collection or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for a Covered Entity.
3. Designated Record Set does not include:
 - (a) Chronolog notes maintained by the contract claims payor;
 - (b) Internal memoranda of the Plan Administrator or contract claims payor;
 - (c) Information created or obtained in anticipation of litigation;
 - (d) Any legally privileged, work product or proprietary information of the Plan; or

- (e) Any legally privileged, work product or proprietary information of the contract claims payor.

What Rights Does a Covered Person Have Regarding Access to or Amendment of PHI?

Upon written request to the Plan, an individual has a right of access to inspect and obtain a copy of PHI about himself/herself in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set except for:

- (a) Psychotherapy notes;
- (b) Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and
- (c) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a to the extent the provision of access to the individual would be prohibited by law, or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

All requests to the Plan for access to PHI must be in writing. The Plan must act on a request for access no later than thirty (30) days after receipt by granting and providing access or providing a written determination as to why access will not be provided. If the PHI requested is not maintained or accessible to the Plan on-site, the Plan may have sixty (60) days to provide the requested access. If the Plan is unable to provide access within these timeframes, the Plan may have an additional thirty (30) days to provide the requested access so long as written notice of the delay and the reasons for it is provided to the requesting individual prior to expiration of the applicable time period.

In providing the requested access, the Plan must timely permit an individual to request access to inspect or to obtain a copy of the PHI about the individual that is maintained in a Designated Record Set. If the Plan is asked to provide a photocopy or summary of the PHI, the individual requesting the PHI will be responsible for any reasonable fees incurred by the Plan in producing the same.

The Plan may deny an individual access to PHI in the following circumstances:

- the PHI is excepted from the right of access,
- the PHI relates to a correctional facility inmate's request,
- the PHI is obtained by a covered health care provider in the course of research that includes treatment,
- the individual's access to the PHI is governed by the Privacy Act and the denial is consistent with the provisions of that Act,
- the PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information, or
- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested by an individual or personal representative is reasonably likely to endanger the life or physical safety of the individual or another person referenced in the PHI.

In some of these instances, the individual is given the right to have such denials reviewed and in others the Plan does not need to provide the opportunity for review of the denial. The Plan will provide the opportunity for review of the denial upon receipt of a written request if required to do so by the regulations. Such review will be performed in the manner, and within the time periods, prescribed in the regulations. Please contact the Plan Administrator if you have questions.

An individual has the right to ask the Plan to amend PHI or a record about the individual in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set. The Plan may deny an individual's request for amendment if it is determined that the PHI or record that is the subject of the request:

- was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
- is not part of the Designated Record Set;

- would not be available for inspection according to the provisions of the applicable regulations; or
- is accurate and complete.

All requests to the Plan for amending PHI must be in writing. The Plan must act on a request for amendment no later than sixty (60) days after receipt by granting the requested amendment or providing a written determination as to why access will not be provided. If the Plan is unable to act on the amendment within these timeframes, the Plan may have an additional thirty (30) days to provide the requested access so long as written notice of the delay and the reasons for it is provided to the requesting individual prior to expiration of the applicable time period. If the request for amendment is granted, the Plan must amend the PHI in the Designated Record Set(s) as requested, must timely inform the individual of the amendment and obtain from that individual relative to other entities who need to be informed of the amendment, and advise those entities and any persons, including business associates, who the Plan knows has the PHI that is the subject of the amendment and may have relied, or could foreseeably rely on such information to the detriment of the individual. If the request for amendment is denied, in whole or in part, the Plan must permit the individual to submit to the Plan a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The Plan may reasonably limit the length of the statement of disagreement. The Plan has the right to prepare a written rebuttal to the individual's statement of disagreement. If such a rebuttal is prepared, a copy of it must be sent to the individual who submitted the statement of disagreement. Where permitted by the regulations, the statement of disagreement and rebuttal will be incorporated into any future disclosures of PHI to which the disagreement relates.

A Covered Person has the right to request restrictions on certain uses and disclosures of PHI as provided by Section 164.522(a) of the HIPAA regulations; however, the Plan is not required to agree to a requested restriction.

A Covered Person has the right to receive confidential communications of PHI as provided by Section 164.522 of the HIPAA regulations.

A Covered Person has the right to receive an accounting of disclosures of PHI as provided by Section 164.528 of the HIPAA regulations.

TO FILE A COMPLAINT, OR TO REPORT A POSSIBLE VIOLATION OF AN INDIVIDUAL'S PRIVACY RIGHTS

Individuals have the right to file a complaint with the Plan and/or the Secretary of the Department of Health and Human Services if they believe their privacy rights have been violated. Any complaint filed with the Plan must be in writing and directed to the Plan Administrator at the address stated in the Summary Plan Description. The regulations provide that no individual will be retaliated against for filing a complaint.

FOR FURTHER INFORMATION

If you have any further questions about the Plan's privacy policy or its administration, please contact the Privacy and Compliance Officer for the contract claims payor at 1-800-877-1122.

AMENDMENT
FLEXIBLE BENEFITS SUMMARY PLAN DESCRIPTION
FOR THE EMPLOYEES OF GEORGE FOX UNIVERSITY

Effective the first day of the first Plan Year beginning after March 31, 2010, the Flexible Benefits Plan for Employees of George Fox University and Affiliates is amended as follows:

1. Within the "BENEFITS PAYMENTS" section, the "What Happens If I Don't Spend All Plan Contributions During the Plan Year" is deleted and replaced with the following:

What Happens If I Don't Spend All Plan Contributions During the Plan Year?

Any monies left at the end of a "grace period", which is a period of not more than two months and fifteen days after the end of the Plan Year, will be forfeited. Obviously, qualifying expenses that you incur during that grace period and for which you seek reimbursement after the end of that grace period will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the grace period. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

GEORGE FOX UNIVERSITY
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION MATERIAL MODIFICATIONS

I
INTRODUCTION

George Fox University has amended your Flexible Spending Account Plan as of January 1, 2011.

This is merely a summary of the most important changes to the Plan. It is presented to you as an addition to the Summary Plan Description. If you have any questions, contact the Administrator. A copy of the Plan, including this amendment, is available for your inspection. If there is any discrepancy between the terms of the Plan or the amendment itself and this summary of material modifications, the provisions of the Plan, as amended, will control.

II
GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Over-the-Counter Rule Change Amendment to the Plan. This information has been summarized for you in this Section.

1. General Plan Information

George Fox University Flexible Benefits Plan is the name of the Plan.

The amended provisions of the Plan become effective on January 1, 2011, unless otherwise provided.

Your Employer has assigned Plan Number 501 to your Plan.

2. Employer Information

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

George Fox University
414 N Meridian Street #6108
Newberg, OR 97132
93-0386839

3. Administrator Information

The name, address and business telephone number of the Administrator are:

George Fox University
414 N Meridian Street #6108
Newberg, OR 97132

The Administrator has the complete power, in its sole discretion to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Administrator is conclusive and binding upon all persons.

III
SUMMARY OF CHANGES

Health Flexible Spending Account:

Drug costs, including insulin, may be reimbursed. "Over-the-counter" drugs and medicines will not be reimbursed without a prescription.