

SECTION I: DESCRIPTION OF FLEXIBLE BENEFIT PLAN

INTRODUCTION TO THE FLEXIBLE BENEFIT PLAN

Bryn Mawr College has a Flexible Benefit Plan for full-time and part-time faculty and staff members who are scheduled to work at least the equivalent of 26 hours per week, 52 weeks per year, or 1,352 hours. Under this plan, each participant elects benefits on an individual basis. Benefits start on the first of the month coincident with or next following the date of hire. The College pays for certain benefits. Participants authorize the College to reduce their salary for the cost of benefits that are not paid for by the College. Please read the following pages carefully so that you can learn how the plan works.

TYPES OF BENEFITS*

Your benefit package will be divided into two parts: **Core Benefits** and **Benefits of Choice**.

CORE BENEFITS

A core benefit is a benefit which Bryn Mawr College provides at no cost to you. These benefits are given to you regardless of your selection of additional benefits. Your core benefits are as follows:

Basic Life Insurance

\$20,000 term life coverage (This amount is reduced by 50% for participants age 70 or older). Insurance is provided by CIGNA.

Long-term Disability Insurance

60% of monthly wage base to a maximum benefit of \$14,000 per month, less Social Security and other offsets. Benefits start after 180 days of total disability as defined by CIGNA, the long-term disability insurance carrier.

Dental Insurance (single coverage)

Insurance is provided by Delta Dental.

Employee Assistance Program

This benefit is provided by Horizon Care™ to assist employees and their families with a wide range of issues, including:

Individual Counseling	Bereavement Counseling
Relationship and Family Counseling	Community Resource Referrals
Legal/Financial Concerns	Substance Abuse

Contact is made by calling the confidential, toll-free number, 1-800-865-3200.

* Your benefits are briefly described in this booklet. Individual booklets with details of all benefits offered through the Flexible Benefit Plan are available in Human Resources.

BENEFITS OF CHOICE

A benefit of choice is a benefit that you will select. Bryn Mawr College provides you with a budget/subsidy to assist you in "buying" your medical plan of choice. In the event you do not need to purchase medical insurance through the College's group plans, you may elect to use the budget to purchase other benefits. Bryn Mawr College has made available the following selection of benefits from which to choose:

Blue Cross/Blue Shield/Major Medical

- Personal Choice PPO
- Personal Choice PPO High Deductible Health Plan (HDHP) with optional Health Savings Account (HSA)

Keystone Health Plan East

- Keystone POS
- Keystone HMO

Dental Insurance (dependent coverage)

- Delta Dental

Supplemental Life Insurance

Cash

EXPLANATION OF COLLEGE BUDGET AND MEDICAL SUBSIDY

The budget is \$120.00 per month and is added to the pay of all Flexible Benefit Plan eligible employees. Eligible employees who do select a medical plan through the College receive an additional medical subsidy. The budget plus the additional medical subsidy equals the College contribution amounts listed on the Rate Sheet.

An employee who waives medical coverage receives the \$120.00 budget amount as taxable income unless she or he selects other benefits, in which case the \$120.00 would offset those costs. If the other benefits selected cost less than \$120.00, the employee will receive the difference as taxable income (see "Taxation of Your Contributions").

In order to waive medical coverage, the employee must document that she or he has comprehensive medical coverage available from a group medical plan that is not affiliated with the College.

Employees who select benefits that cost more than the amount of the budget plus the additional medical subsidy, will have their taxable income reduced by the amount of the difference (see "Taxation of Your Contributions").

Please refer to the separate Rate Sheet for benefit costs.

TAXATION OF YOUR CONTRIBUTIONS (See separate section for Domestic Partners)

Any contributions you make under the Flexible Benefit Plan are not subject to federal withholding, Pennsylvania State and Social Security (FICA) taxes for the following plans:

1. Medical Insurance
2. Dental Insurance
3. Employee Supplemental Life Insurance - for amounts up to and including \$30,000

Since employee contributions to the Flexible Benefit Plan are not subject to FICA taxes, Social Security income upon retirement may be affected.

IRS Code provides that employee group life insurance coverage in excess of \$50,000, including both employer-paid and employee-paid coverage, must be reported as imputed income. The amount of imputed income is determined not by the actual premium paid, but is instead based on a uniform premium established by the IRS. The amount of imputed income is subject to FICA and federal income taxes, but not to Pennsylvania state tax. See "Life Insurance Valuation" on the Human Resources web site, for more information.

There is no income reduction at the state or federal levels for life insurance premiums paid for spouse, domestic partner and/or dependent children coverage.

PLEASE NOTE Medical and dental insurance premiums paid by you through payroll may not be used as a tax deduction when filing Schedule A (Question 1) Form 1040.

TAXATION OF DOMESTIC PARTNERS CONTRIBUTIONS

Any contributions made by the College or the employee for domestic partners coverage are subject to federal withholding, Social Security (FICA) and Pennsylvania State Tax. The IRS does not recognize domestic partners in their definition of an eligible dependent, and for this reason, domestic partners coverage is provided outside of the Flexible Benefit Plan as a fully taxable benefit. The tax benefits will remain in effect for College and employee contributions attributable to the employee's own coverage.

EXAMPLE:

Medical Plan Premium - Employee Plus Partner	\$1,200 per month
Budget/Subsidy - Employee Plus Partner	\$1,000 per month
Budget/Subsidy - Employee Only	\$500 per month

The amount subject to federal withholding, Social Security and Pennsylvania State Tax is \$700, the difference between the full premium cost for employee plus partner coverage and the budget/subsidy for single coverage.

IF YOU ARE MARRIED TO ANOTHER BRYN MAWR EMPLOYEE AND HAVE CHILDREN

Dental

Married employees with one dependent child should enroll as one single and one parent & child contract. Married employees with two or more dependent children should be enrolled as a family by the higher-paid employee. The lower-paid employee should elect single coverage on the Flexible Benefit Election Form. Insurance forms will be completed so that the lower-paid employee is a dependent of the higher-paid employee. The higher-paid employee will receive a dental subsidy equivalent to two times the cost of single dental coverage.

EXAMPLE:

Cost of family dental coverage:	\$90
Cost of single dental coverage:	\$25

The higher-paid employee should enroll for family coverage at \$90 per month. The lower-paid employee's subsidy will be added to the higher employee's subsidy. The combined subsidy of \$50 per month will be applied against the cost of family dental coverage. The net effect is that the higher-paid employee's pay will be reduced by \$40 per month.

Medical

Married employees with children who elect the same Keystone plan should enroll as one single and one parent & child(ren) contract. Married employees with children who both enroll in Personal Choice should contact Human Resources. The College will adjust employee contributions if the married employees would otherwise be financially discouraged from enrolling in a manner that is least expensive to the College.

In this situation, the entire family should be enrolled by the higher-paid employee. The lower-paid employee should elect single coverage on the Flexible Benefit Election Form. Insurance forms will be completed so that the lower-paid employee is a dependent of the higher-paid employee. The employee contribution for the higher-paid employee will be adjusted to the equivalent of what both employees would have paid if they had elected coverage based on the employee contributions on the enclosed Rate Sheet.

Please contact Human Resources if you have any questions on these provisions.

CHANGES IN YOUR BENEFIT SELECTION

New Employment Status

You may enroll in the Flexible Benefit Plan within 31 days of the date you first become eligible. Coverage will be effective the first of the month coincident with or following employment at a benefits-eligible level.

Open Enrollment

You will be given an opportunity to make changes in your benefit selections once each year. This period of time is referred to as Open Enrollment, and will be held for a three-week period beginning in September and prior to the start of the new plan year effective November 1. Notices will be distributed to all employees eligible to participate in the Flexible Benefit Plan. Please note that employees with newly eligible dependents as the result of federal health care reform will have a special election period that extends to 30 days.

Life/Qualifying Event Changes

Benefit selections are fixed for each plan year. The IRS allows a change only if you have experienced what is referred to as a "life" or "qualifying" event. Examples of a "life/qualifying" event which may necessitate a change in your benefit selection at a time other than Open Enrollment include marriage, divorce or annulment, death, birth or adoption, loss of alternative group health coverage or the availability of alternative group health coverage. Having to change providers because a doctor or dentist no longer participates in a network plan is not a "life/qualifying" event. Documentation of the "life/qualifying" event change must be provided to Human Resources within 31 days of the occurrence in order to change your benefit selections. If "life/qualifying" event changes are **not reported within 31 days** of the occurrence, benefit selections cannot be changed until the start of the new Plan Year, November 1. This period will be extended under two scenarios, as required by the Children's Health Insurance Program Reauthorization Act (CHIPRA):

1. The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility;
2. The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

An employee must request this special enrollment within 60 days of the loss of coverage in the first scenario, and within 60 days of when eligibility is determined in the second scenario.

Dependent Child Definition

Effective November 1, 2010, children are eligible for medical and dental insurance coverage through the end of the calendar year in which the child turns 26. Effective November 1, 2011, dependent child life insurance coverage is also available through the end of the calendar year in which the child turns 26. This is independent of financial dependence, residence, student status or marital status. Eligibility is not extended to the spouse or children of the eligible adult child.

FAMILY AND MEDICAL LEAVE ACT

In accordance with the Family and Medical Leave Act of 1993, an employee who has completed one full year of service and worked at least 1,250 hours may request unpaid leave for:

- The birth or adoption of the employee's child, or the placement in the employee's home of a foster child
- Care of a spouse, son, daughter, or parent who has a serious health condition

-For a qualifying exigency due to the fact that an employee's spouse, domestic partner, son, daughter or parent is either on active duty or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation

- The employee's own serious health condition which prevents the employee from performing her/his job.

The maximum length of unpaid leave is twelve weeks in a twelve-month period, except that the maximum is 26 weeks in a twelve-month period for an employee who is caring for a covered service member who is the spouse, domestic partner, son, daughter, parent or next of kin of the employee. During this time, the employee is entitled to the continuation of College contributions to the Flexible Benefit Plan. If the employee does not return to work at the conclusion of the leave, the College may recover the cost of the health insurance premiums, up to the subsidy amount, paid during the leave.

An employee is expected to give written notice at least 30 days in advance of her/his intention to take a leave. The employee is also expected to provide medical certification in instances where the reason for the leave is the illness of the employee or a family member. In the case of leave due to the active duty of a family member, certification will be based on the requirements of the Department of Labor. Please contact Human Resources with any questions.

FLEXIBLE BENEFITS

Choosing Medical Coverage

To assist you in choosing a medical plan, the College provides a comparison of benefits for each medical insurance plan offered. For a clear description of the medical plans, please refer to the appropriate descriptive booklets provided by each of the medical insurance carriers.

Waiving Medical Coverage

Bryn Mawr College requires benefits-eligible employees to have medical insurance because medical care costs can be enormous. Medical coverage provides financial security to meet these sometimes unexpected costs.

You may waive medical insurance only if you have group medical insurance coverage elsewhere and present the name and policy number of the plan on the Flexible Benefit Plan Election Form. If you have medical coverage, you may want to consider using your budget for other benefits.

In order to maintain continuance of a medical insurance waiver, you must make an election each year during the Open Enrollment. If this does not occur, the waiver will be rescinded.

Medical Plan Re-entry

If you waive the Bryn Mawr College Medical Plan because you have coverage under a spouse or partner's plan, or other comparable medical insurance, you may join any of the medical options offered through the College's program if you lose that other medical coverage (See "Changes in Your Benefit Selection - Life/Qualifying Event Changes"). Confirmation of loss of coverage must be provided to Human Resources within 31 days of the termination date for the other medical coverage.

MEDICAL PLAN OPTIONS

Personal Choice PPO

Personal Choice is a Preferred Provider Organization (PPO) and is designed to allow you to choose your health care providers from a network. Unlike an HMO, you do not need to enroll with a primary care physician and you do not need a referral to see a specialist.

You receive maximum benefits by selecting physicians, specialists and facilities from the network directory. There is a \$20 co-payment for office visits to a network primary care physician and a \$30 co-payment for office visits to a network specialist. Care can be obtained outside of the Philadelphia area on an in-network basis by using the BlueCard® PPO program. Prescriptions obtained at a network pharmacy are subject to a \$20 generic, \$40 brand name formulary and \$60 brand name non-formulary co-payment. A mail-order prescription program is also available. Routine vision exam and glasses/contact lenses reimbursement is available every two years.

There is a \$150 emergency room co-payment that is waived if admitted from the emergency room to the hospital. There is a \$150 per day hospital co-payment that is capped at 5 days per admission and a \$150 co-payment for outpatient surgery.

When using providers and facilities outside the network, you will pay more out-of-pocket costs for benefits and services, including an annual deductible of \$500 and coinsurance of 70% of allowed charges. Inpatient and selected outpatient services obtained out of the network must be pre-authorized. Section II includes plan summary information and more detailed plan information is available on the Human Resources web site.

Personal Choice PPO High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Option

An HDHP meets conditions established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The purpose of this legislation was to create medical plans that shift upfront medical costs to enrollees, resulting in a lower and more affordable premium. HDHP enrollees may be eligible to fund unpaid medical expense through a pretax HSA that provides more flexibility than an FSA.

The HDHP sponsored by the College uses the same network as the regular Personal Choice plan. However, the HDHP provides no coverage for in-network services (with the exception of preventive services and routine vision care) until an annual deductible has been met. The plan year deductibles are \$1,500 for single coverage and \$3,000 for family coverage. The preventive services that are covered without any deductible or copayments have been determined by health care reform legislation and are listed on the Human Resources web site. A routine vision exam and glasses/contact lenses reimbursement is available every two years and is not subject to the annual deductible.

Once the \$1,500 or \$3,000 deductible is met, in-network expenses are reimbursed at 100%. The exception is for prescriptions, which are reimbursed subject to a \$5 generic, \$20 brand name formulary and \$45 brand name non-formulary copay once the applicable deductible has been met. A mail-order prescription program is also available. Unlike the regular Personal Choice plan, the individual deductible does not apply to family enrollment. The \$3,000 must be met in its entirety under a family contract before 100% in-network coverage goes into effect.

HDHP enrollees who use in-network providers should not pay for services on the date of the visit. An explanation of benefits will be mailed by Independence Blue Cross after the visit has occurred which will specify the exact amount that is to be paid to the in-network provider.

When using providers and facilities outside the network, you will pay more out-of-pocket costs for benefits and services, including an annual deductible of \$5,000 for single and \$10,000 for family coverage. Once the deductible is met, coinsurance is 50% of allowed charges. Inpatient and selected outpatient services obtained out of the network must be pre-authorized.

The HSA is an optional feature of the HDHP and can be used to pay for medical expenses with pretax dollars. Annual contributions to the HSA are determined by the IRS. The maximum annual contribution that an individual, with individual coverage, can make to an HSA is \$3,050 for 2011 and \$3,100 for 2012. In the case of a family, with family coverage, the maximum annual contribution is \$6,150 in 2011 and \$6,250 in 2012. HSA holders age 55 and older may make an additional annual contribution of \$1,000.

HSA participation is limited to HDHP enrollees who have no other health coverage, which includes an FSA health care savings account. If an employee is enrolled in the College health care savings account and participates in the HDHP, contributions to the HSA will be restricted until the next calendar year. HDHP enrollees should also not participate in the HSA if enrolled in Medicare (Parts A or B) or Medicaid.

HSA contributions will be deposited into an FDIC-insured account that each participant establishes at The Bancorp Bank, the vendor selected by Independence Blue Cross to provide HSA services. This is done by completing the *Independence Blue Cross HSA Enrollment Request* form, which is available on the Human Resources web site. After the HSA account is opened, participants should elect the HSA contribution to be deducted from each pay by completing the *HDHP HSA Contribution Form*, which is also available on the Human Resources web site.

Bancorp HSA enrollees will receive a debit card and checks for which distributions from the account will be made. Unlike an FSA, there is no “use it or lose it” provision, so funds in the account do not need to be used before the end of the plan year. Distributions are tax-free for qualified medical expenses. Unlike an FSA, no one other than the account holder will monitor the distribution process. If a distribution is made for non-qualified medical expenses, the amount withdrawn will be subject to income tax and may be subject to an excise tax as well. Any fees incurred on the account are the responsibility of the account holder. Fee information is available on the Human Resources web site.

Any individual who participates in an HSA must complete IRS Form 8889 when filing the Form 1040 income tax return. While the College will not deduct more than the annual individual or family maximum for the applicable plan year, whether the deduction is in fact permissible in its entirety will be determined on Form 8889.

Section II includes plan summary information and more detailed plan information is available on the Human Resources web site.

Keystone POS

Keystone Point-of-Service (POS) is a health care program which will give you the flexibility to receive referred care provided by your primary care physician or referred specialist at little or no cost or obtain self-referred care from a physician of your

choice that can be reimbursed subject to a \$200 deductible and coinsurance of 80% of allowed charges.

A POS plan is positioned between a PPO and an HMO. Like an HMO, you do need to enroll with a primary care physician. However, when you require care, - the “point-of-service” - you choose whether to seek that care through your primary care physician (referred care) or from any other provider (self-referred care).

A POS plan is similar to a PPO in that there is a high and a low level of coverage available. However, a POS plan requires that you enroll with a single primary care physician and that a referral be provided in order to receive the higher level of coverage. By contrast, you do not enroll with a primary care doctor in a PPO, and you can self-refer to an in-network specialist and receive the higher level of benefits in a PPO.

There is a \$15 co-payment for office visits to your primary care physician and a \$25 co-payment for office visits to a referred specialist. Prescriptions obtained at a network pharmacy are subject to a \$15 generic, \$35 brand name formulary and \$50 brand name non-formulary co-payment. A mail-order prescription program is also available.

There is a \$150 emergency room co-payment that is waived if admitted from the emergency room to the hospital. There is a \$100 per day hospital co-payment that is capped at 5 days per admission and a \$50 co-payment for outpatient surgery. Section II includes plan summary information and more detailed plan information is available on the Human Resources web site.

Keystone HMO

Keystone Health Maintenance Organization Plan (HMO) provides comprehensive health services including preventive care (routine visits) provided physicians and hospitals in the network are used and that the care is coordinated by a primary care physician.

There is a \$15 co-payment for office visits to your primary care physician and a \$25 co-payment for office visits to a referred specialist. Prescriptions obtained at a network pharmacy are subject to a \$15 generic, \$35 brand name formulary and \$50 brand name non-formulary co-payment. A mail-order prescription program is also available. Except for emergency situations, no coverage is available unless your primary care physician has coordinated treatment.

There is a \$150 emergency room co-payment that is waived if admitted from the emergency room to the hospital. There is a \$100 per day hospital co-payment that is capped at 5 days per admission and a \$50 co-payment for outpatient surgery. Section II includes plan summary information and more detailed plan information is available on the Human Resources web site.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Continuation of medical coverage is available through Bryn Mawr College to all qualified individuals under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. Coverage is available for the statutory periods at the individual's expense.

Women's Health and Cancer Rights Act

This 1998 federal law requires all group medical plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group medical plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

DENTAL PLAN

Delta Dental is a dental program that offers the flexibility of using any dentist, or using a Delta Dental of Pennsylvania participating dentist. The College uses the Delta Dental “PPO plus Premier” Network. A Delta Dental PPO participating dentist has agreed to accept Delta Dental’s PPO maximum plan allowance as payment in full. A Delta Dental Premier participating provider has agreed to accept Delta Dental’s Premier maximum plan allowance as payment in full. Non-participating providers will be paid at the Premier maximum plan allowance, but may bill for charges in excess of that amount. In general, the Premiere maximum plan allowance is higher than the PPO maximum plan allowance.

Coverage is 100% of the applicable allowance for preventive and diagnostic services, 80% of the applicable allowance for basic services, and 50% of the applicable allowance for major services and for child orthodontics. There is an annual maximum of \$1,500 per calendar year, and a \$1,500 lifetime maximum for child orthodontics. The annual calendar year deductible of \$50 per person (\$150 per family) is waived for preventive and diagnostic services.

Section II includes plan summary information and more detailed plan information is available on the Human Resources web site.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Continuation of dental coverage is available through Bryn Mawr College to all qualified individuals under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. Coverage is available for the statutory periods at the employee's expense.

SUPPLEMENTAL LIFE INSURANCE

You may purchase supplemental term life insurance in increments of \$10,000, to a maximum of \$300,000. Employees have a guaranteed issue amount of \$50,000, provided that they enroll within 31 days of initial eligibility in the Flexible Benefit Plan.

Any amount of supplemental employee life insurance that is not guaranteed issue is subject to medical underwriting by the insurance carrier, CIGNA, at the time of the election. You will need to complete a medical questionnaire and submit it to the insurance carrier immediately upon election. The insurance carrier will advise whether your request for supplemental life insurance is approved or disapproved.

You may purchase dependent term life Insurance for your spouse or domestic partner in increments of \$10,000, to a maximum of \$300,000. Your spouse or domestic partner will also be subject to medical underwriting based on the same rules that apply to employees. You may purchase \$2,500; \$5,000; \$7,500; or \$10,000 dependent term life Insurance for your children up to age 26.

Life insurance purchased for dependents is on an after-tax basis. The first \$50,000 in employee life insurance is on a pretax basis, which applies to the basic life insurance of \$20,000 and the first \$30,000 in supplemental life insurance. Employee life insurance in excess of \$50,000 is treated as imputed income by Internal Revenue Code §79, based on the following valuations per \$1,000 of coverage per month:

<u>Age</u>	<u>Value per \$1,000 of coverage per month</u>
Under 25	\$.05
25-29	\$.06
30-34	\$.08
35-39	\$.09
40-44	\$.10
45-49	\$.15
50-54	\$.23
50-59	\$.43
60-64	\$.66
65-69	\$1.27
70 and above	\$2.06

FLEXIBLE SPENDING ACCOUNT PLAN

All employees who are eligible to participate in the Flexible Benefit Plan are also eligible to participate in the Flexible Spending Account Plan. The Flexible Spending Account Plan allows pre-tax contributions for dependent care and medical care. Open Enrollment for the Flexible Spending Account Plan occurs in November, for a January 1 effective date. Please note that enrollees in the Personal Choice HDHP cannot make contributions to an HSA while covered by an FSA.

BASIC RETIREMENT PLAN

The College will continue to maintain its pension contribution level to the Bryn Mawr College Retirement Plan for all eligible employees. Investment options are available through Teachers Insurance and Annuity Association - College Retirement Equities

Fund (TIAA-CREF) and the Vanguard Group. The pension plan is not part of the Flexible Benefit Plan, and College contribution is unaffected by Flexible Benefit Plan elections. Please refer to the Employee Handbook or Bryn Mawr College Retirement Plan Summary Plan Description for details.

SUPPLEMENTAL RETIREMENT PLAN

All employees are eligible to make their own contributions to their retirement plan (TIAA and/or Vanguard) with budget dollars and from salary on a salary reduction (pre-tax) basis. There is an annual limit on contributions set by the IRS Code.

In order to contribute on a pre-tax basis toward your retirement, you must sign a Salary Reduction Agreement, which is available in Human Resources and on the Human Resources Web page. Salary reduction contributions are not subject to the Open Enrollment limitations of the Flexible Benefit Plan. Changes in the amount of salary reduction may be made at the start of any pay period, subject to an annual limitation on the maximum number of changes made within one calendar year. Please refer to the Employee Handbook or Bryn Mawr College Retirement Plan Summary Plan Description for details.

DOCUMENTS

There are legal documents describing all aspects of the plan. It will be important for you to read the documents as they are presented to you. This booklet is a brief description to help you make your decisions when you become a plan member. If there is any difference between your interpretation of this booklet and the information given in the plan documents, the plan documents are considered the determining source of information.

Bryn Mawr College intends this plan to be permanent. However, the plan may be amended or terminated at any time and is not a guarantee of future employment. The plans described reflect the impact of current tax legislation and may change in the future if tax law changes.

STATEMENT OF EMPLOYMENT RETIREMENT INCOME SECURITY ACT (ERISA) RIGHTS

Participants in this plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- (1) Examine, without charge, at the Plan Administrator's office, all plan documents, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.*
- (2) Obtain copies of all plan documents and other information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- (3) Receive a summary of the plan's annual ERISA report to the Department of Labor. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

ERISA sets forth the duties of the people who are responsible for the operation of this plan. The people who operate the plan have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including the employer, may discharge or otherwise discriminate against participants in any way to prevent them from obtaining benefits to which they are entitled under the plan or exercising their rights under ERISA. If an application for benefits under the plan is denied in whole or in part, the participant or beneficiary must receive a written explanation of the reasons for denial. Participants have the right to have the Plan Administrator review and reconsider denied applications or requests on eligibility, participation, or other aspects of the operation of the plan, and to have Bryn Mawr College review and re-consider denied claims. Under ERISA, participants may take steps to enforce these rights. For example, if a participant requests materials from the plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to \$100 a day until he or she receives the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If a claim for benefits is denied or ignored, in whole or in part, the participant may file suit in a state or federal court.

* Summary Annual Reports are mailed periodically to Participants. They may be reviewed and copied at any time. If the Plan Administrator's responsibility to remit plan premiums is not discharged according to the terms of this plan, or if a participant is discriminated against for asserting ERISA rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, for example, if the court finds the claim is frivolous, the court may order the participant to pay the costs and fees.

Contact the Plan Administrator if you have any questions about this plan. Bryn Mawr College expects the Flexible Benefit Plan to continue indefinitely, but reserves the right to terminate it or amend it. Bryn Mawr College also reserves the right to suspend contributions if it is determined that continuation of contributions is impossible or inadvisable. If the plan is terminated, or if the College contributions to the plan are permanently discontinued, each participant will be entitled to receive the amount in her/his account, according to the provisions of the plan.

Questions about this statement or about rights under ERISA may be directed to the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

IDENTIFYING DATA: Employer ID Number: 231352621

Plan Number: 507 Bryn Mawr College Employee Benefit Plan

Plan Year: November 1, 2011 - October 31, 2012

Plan Administrator: Joseph Bucci, Director of Human Resources
Bryn Mawr College
Bryn Mawr, PA 19010

November 1, 2011.