

**Reed College
Welfare Benefits Plan**

**Plan Document
and
Summary Plan Description**

Amended and Restated Effective January 1, 2022

How To Use Your Plan Document/Summary Plan Description

This document, together with policies, insurance contracts, summary plan descriptions, and other benefit summaries prepared by the carriers and administrators listed in Appendix A (which are incorporated by reference), constitutes the written plan document required by the Employee Retirement Income Security Act of 1974 (“ERISA”) Section 402 and the Summary Plan Description required by ERISA Section 102 for the Reed College Welfare Benefit Plan (“Plan”). You may receive documents related to the benefits listed in Appendix A directly from the applicable carriers or administrators or from the Employer. All policies, insurance contracts, summary plan descriptions, and other benefit summaries prepared by the carriers and administrators listed in Appendix A for benefits under this Plan are incorporated herein through this reference. Please read them carefully and refer to them when you need information about how your Plan works. This document is also a wonderful source to learn about the benefits available to you through this Plan. This restated document is effective as of January 1, 2022. Certain benefits listed herein may not be subject to the requirements of ERISA and inclusion herein is not intended to subject such benefits to the requirements of ERISA. Benefits that are included but not subject to ERISA are provided for information only.

DEFINITIONS

Capitalized terms used in the Plan have the following meanings. For a definition of any other term not specifically defined herein, you should first refer to any supplemental documents which you may receive from the Employer or a particular insurance company directly.

AD&D	“AD&D” means accidental death and dismemberment insurance.
COBRA	“COBRA” means the Consolidated Omnibus Budget Reconciliation Act and its underlying regulations.
Code	“Code” means the Internal Revenue Code of 1986, as amended and its underlying regulations.
Dependent	“Dependent” means your child, Domestic Partner, or Spouse, , as defined in the terms of the Governing Documents, published by the carriers and administrators.
Employee	“Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll. Any Employee who is reclassified as a common-law employee shall be an Employee prospectively only.
Employer	“Employer” means Reed College or any successor thereto and shall not include any other related employer or affiliated service group unless specifically agreed to by Reed College and such employer has duly adopted this Plan.
ERISA	“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.
Governing Documents	“Governing Documents” means the insurance contracts, plan documents, plan materials, benefits guides, and other related material prepared by the vendors listed in Exhibit A and the Employer.
Health Care FSA	“Health Care FSA” means the health care flexible spending account plan established by the Employer under a separate cafeteria plan document. The Health Care FSA is a component benefit plan under this Plan. It allows you to use pre-tax dollars to pay for eligible health plan expenses not reimbursed under other plans.
HIPAA	“HIPAA” means the Health Insurance Accountability and Portability Act of 1996, as amended, and its underlying regulations.

HITECH	“HITECH” means the Health Information Technology for Economic and Clinical Health Act.
MHPA	“MHPA” means the Mental Health Parity Act.
MHPAEA	“MHPAEA” means the Mental Health Parity and Addiction Equity Act.
NMHPA	“NMHPA” means the Newborns’ and Mothers’ Health Protection Act of 1996, as amended and its underlying regulations.
Plan	“Plan” means this Reed College Welfare Benefit Plan.
Plan Administrator	“Plan Administrator” means Reed College.
Plan Sponsor	“Plan Sponsor” means Reed College.
PPACA	“PPACA” means The Patient Protection and Affordable Care Act.
Spouse	“Spouse” means an individual who is legally married to an Employee as determined under applicable state and/or federal law.
WHCRA	“WHCRA” means the Women’s Health and Cancer Rights Act of 1998, as amended and its underlying regulations.

INTRODUCTION

The Employer maintains the Plan for the exclusive benefit of its eligible employees and their Spouses, Domestic Partners, and other Dependents. The Plan provides benefits through the following component benefit programs:

- Medical;
- Dental;
- Vision
- Health Flexible-Spending Account (FSA)
- Employer Assistance Program (EAP);
- Long-Term Disability;
- Short-Term Disability;
- Life;
- AD&D;
- Retiree Medical; and
- Retiree HRA

Certain of these component benefit programs require you to make an annual election to enroll for coverage. Please refer to the specific component benefit materials for details regarding annual enrollment requirements. Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the Employer. A copy of each booklet, summary or other governing document is incorporated by reference in Appendix A. The insurance booklets and other summary documents produced for component parts of this Plan are hereby incorporated by reference to the carrier or administrator for a component benefit program. Please note that certain benefits listed may not be subject to ERISA. Any reference herein to ERISA shall not subject such plans to the regulations and requirements of ERISA.

GENERAL PLAN INFORMATION

Plan Name:	Reed College Welfare Benefits Plan
Type of Plan:	ERISA Employee Welfare Benefit Plan
Plan Year:	January 1-December 31
Plan Number:	515 (active employee plan); 525 (retiree plan)
Effective Date:	The Plan was originally effective on July 1, 1998. It is restated effective January 1, 2022.
Plan Sponsor:	Reed College
Plan Sponsor's Employer Identification Number:	93-0386908
Insurance Companies/Vendors or administrators:	Kaiser Permanente Willamette Dental MetLife Standard Insurance Company EAP Allegiance Please see Appendix A for addresses and customer service telephone numbers.
Plan Administrator:	Reed College 3203 SE Woodstock Blvd. Portland, OR 97202 (503) 777-7705
Agent for Service of Legal Resident Process:	Reed College 3203 SE Woodstock Blvd. Portland, OR 97202 (503) 777-7705
Funding Medium and Type of Plan Administration:	With the exception of the Health Care FSA, all benefits under the Plan are fully-insured.

With the exception of the Health Care FSA, the benefits provided under this Plan are fully insured. For all other benefits except the Health Care FSA, Reed has entered into contracts with various insurance companies to provide Plan benefits. The various insurance companies are responsible for paying the Plan benefits. Claims for benefits are sent to the various insurance companies and the claims are processed in accordance with the terms listed in the incorporated booklets prepared

by the various insurance companies. Reed and various insurance companies are responsible for administering the Plan as outlined below.

Reed and employees both may contribute towards the cost of the coverage under the Plan. Reed's portion of the contributions is paid out of Reed's general assets. The employees' share of the contributions is made through employees' pre-tax or after-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums when an employee is initially eligible, during the initial and subsequent open enrollment periods, and upon request for each of the component benefit programs, as applicable. The Plan Administrator reserves the right, at any time, to modify the amount employees have to contribute to participate in the Plan.

Benefits hereunder are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by the Employer. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

Eligibility and Participation

An eligible employee with respect to the Plan will be any common-law employee of Reed who is eligible to participate in and receive benefits under one or more of the component benefit programs. To be eligible to participate in the Plan, you must meet the requirements detailed in this document and/or the applicable Governing Document.

An eligible employee must affirmatively enroll in each of the component plans and may elect to waive coverage.

Active Employee Benefits

An Employee who is normally scheduled to work as a .5 full-time employee (FTE) is eligible for active employee benefits (as further explained below), except for employees in the following categories:

- employees covered by a collective bargaining agreement to which the Plan Sponsor is a party and which does not provide for participation in the Plan;
- “leased employees” within the meaning of Internal Revenue Code Section 414(n);
- individuals from whom the Plan Sponsor does not withhold federal income and employment taxes from such person’s compensation; and
- employees who are students of Reed College are not eligible for active employee benefits except that they will be eligible for the medical coverage if they work sufficient hours under a measurement period, as further explained below.

Additional details regarding eligibility for active employee benefits:

- For purposes of the medical component part, measurement and stability periods are used to determine whether an employee has worked sufficient hours to qualify for coverage.
- Life and AD&D benefits vary by class, as described in the underlying insurance documents incorporated through Appendix A.

Eligibility for all Medical Component Parts:

Employee Classifications and Measurement Methods			
Employee Classification	Measurement Method	Initial Measurement and Stability	Standard Measurement and Stability
Hourly	Look Back Measurement	Measurement: 11 Months Stability: 11 Months	Measurement: 12/1-11/30 Admin: 12/1-12/31 Stability: 1/1-12/31
Salaried	Monthly Measurement	Measurement: 11 Months Stability: 11 Months	Measurement: 12/1-11/30 Admin: 12/1-12/31 Stability: 1/1-12/31

Determination of Eligible Status of Employees

Look-back Measurement Method for Full-time Status Determination (Hourly Employees)

Effective April 1, 2015, the Employer uses the look-back measurement method for employees to determine who is a full-time employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) guidance under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

Look-Back Measurement Method/ Waiting Period (New Hires)

Benefits Eligible Hires

Employees who are hired with the expectation that they will work at a level of at least a .5 FTE (20 hours or 18.5 hours per week, depending on the position), will be eligible for coverage as of the first of the month following hire.

Variable Hour and Seasonal Hires

Employees who are hired on a variable hour or seasonal basis, which includes all employees who are current students of Reed College, must complete an initial measurement period before the Employer can determine whether they will be eligible for coverage. Variable hour and seasonal employees must average 30 or more hours per week during a measurement period to qualify for coverage during a subsequent stability period. Variable hour and seasonal employees who average at least 30 hours per week during a measurement period are referred to as “ACA Full-Time Employees” in this document.

Initial Measurement Period: This means the period beginning on the start of the first month following the Employee’s start date (or Employee’s start date if employee’s first day of employment is the first of the month) and ending twelve (12) months later. Your hours of service during the initial measurement period will determine your Plan eligibility for the stability period that follows the measurement period and any administrative period.

Initial Administrative Period: An initial administrative period is a short period between the initial measurement period and the initial stability period (described below) when the Employer performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The Administrative Period can be split for new employees, including the period between a new employee’s date of hire and the beginning of the Initial Measurement Period, and the period between the end of the measurement period and the beginning of the stability period. The administrative period lasts one month.

Initial Stability Period: The initial stability period is a period that follows the initial measurement period and initial administrative period. Your hours of service during the initial measurement period will determine whether you are a full-time employee who is eligible for coverage during the initial stability period. This period means the twelve (12) months immediately following the end of the initial measurement period and an initial administrative period.

As a general rule, your status as an ACA Full-Time Employee or a non-ACA-Full-Time Employee is “locked in” for the initial stability period, regardless of how many hours you work during the initial stability period, as long as you remain an employee of the Employer. There are exceptions to this general rule for employees who experience certain changes in employment status. If your status changes during a stability period, the Employer will reach out to you to discuss the implications for your eligibility.

Look-Back Measurement Method (Ongoing Employees)

Eligibility for ongoing employees will be determined as follows:

Employees who are not variable hour or seasonal employees: In order to maintain or qualify for medical benefits, these employees must work at an average level of at least a .5 FTE (20 or 18.5 hours per week, depending upon the position) during the Standard Measurement Period.

Variable Hour and Seasonal Employees (which includes all Employees who are current students of Reed College): In order to maintain or qualify for medical benefits, these employees must work at an average of 30 hours per week during the Standard Measurement Period.

Standard Measurement Period: This means the twelve (12) month period beginning with December 1 of year 1 and ending November 30 of year 2. Your hours of service during the standard measurement period will determine your Plan eligibility for the standard stability period that follows the standard measurement period and any standard administrative period.

Standard Administrative Period: The standard administrative period is a short period between the standard measurement period and the standard stability period (described above) when the Employer performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period lasts one month.

Stability Period: This period means the twelve (12) months (i.e., the plan year) immediately following the end of a Standard Measurement Period and the Standard Administrative Period. As a general rule, your status as an eligible or ineligible employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Employer. There are exceptions to this general rule for employees who experience certain changes in employment status. If your status changes during a stability period, the Employer will reach out to you to discuss the implications for your eligibility.

The rules for the look-back measurement method are very complex. Keep in mind that this information is just a summary of how the rules work. More complex rules may apply to your situation. Reed College intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact human resources.

Coverage

Subject to the terms of the governing documents, an eligible Employee may cover the following Dependents under an applicable component benefit program, unless they reside outside the United States:

- Current Spouse;
- Employee's or Spouse's
 - Natural child
 - Legally-adopted child (including children placed with Employee for the purpose of adoption)
 - Step-children; or
 - Children for whom Employee or Employee's Spouse are legal guardians

Special Rule for Adopted Children

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Special Enrollment Rights

In certain special circumstances, you and/or your dependents may enroll in the Plan at times other than open enrollment. The incorporated certificate of insurance booklets/summary plan descriptions and the Plan's Special Enrollment Notice contain more information about potential special enrollment rights.

Effective Date of Coverage

Coverage for a Spouse or other Dependent of an Employee, who is enrolled in the Plan during the Employee's initial or annual enrollment, shall take effect at the same time as the Employee's coverage.

Coverage will be effective for a:

- newborn child as of the date of birth;
- for a newly-adopted child as of the date of adoption or placement for adoption (whichever comes first); and
- for a child for whom you have been appointed legal guardian from the moment the child is placed in your physical custody.

However, you must first be enrolled in the Plan and the Plan Administrator must receive any required employee-premium for the coverage within 31 days of you acquiring the child for the applicable component benefit program after the birth or adoption.

Coverage for a new Spouse or other new Dependent of an Employee will otherwise take effect on the date specified by the governing documents of the component benefit program.

You may also be required to increase your contributions accordingly.

Enrollment Information

New Employees: You will receive enrollment information during your first 30 days of becoming eligible.

Current Employees: You will receive enrollment information during the open enrollment period.

Termination of Participation

Subject to a Participant's continuation right under the insurer's contracts for the benefits covered by this Plan, a covered Employee's participation in the Plan under the component benefit programs that are group health plans will generally terminate on the last day of an Employee's employment with the Employer. Refer to the terms of the Governing Documents for more details and for information about continuing coverage under any benefits after termination from employment. Coverage may also terminate if a covered Employee fails to pay their share of an applicable premium; if a covered Employee's hours drop below any required hourly threshold; if a covered Employee submits false claims; or for any other reason as set forth in the certificate of insurance booklets, benefit summaries, or other governing documents for the component benefit programs referred to in Appendix A.

Retiree Benefits

Reed offers retiree medical benefits to assist retirees in payment for the cost of private insurance and to supplement Medicare coverage.

To be considered a Reed retiree, you must meet both of the following:

- Age 55 or older
- Are a regular employee of the college in a benefits eligible position for at least 20 years

Retirees who are age 65+ are required to have Medicare Parts A and B in order to be eligible for retiree benefits through Reed.

Spouse/domestic partner and dependent children eligibility. The following Spouses, Domestic Partners, and other Dependents are eligible to enroll in Retiree Benefits at the time of the Employee's retirement:

- A spouse to whom the employee is legally married at the time of retirement;
- A Domestic Partner whose partnership is in effect at the time of retirement; and
- Dependent children of the eligible employee, up to age 26.

Duration of eligibility:

- Retirees will be eligible for their lifetime.
- Spouses will be eligible so long as they remain married to the retiree.
- Domestic partners will be eligible so long as they remain in partnership with the retiree.
- Dependent children will remain eligible up to age 26 generally, but longer under certain conditions.
- Spouses and domestic partners of deceased retirees remain eligible, as do children up to age 26.

Retiree Insurance Coverage

Retirement for those hired prior to July 1, 2006

Employees who are age 65+ or Medicare eligible have three options: Kaiser Senior Advantage, Emeriti with Aetna insurance or Emeriti as a HRA.

Early Retirement (age 55-64)

Retirees who are age 55+ with 20 years of service with Reed, are eligible for retirement healthcare benefits. Early retirees remain in the same medical plans that Reed offers its regular employees. Upon reaching age 65, early retirees become regular retirees and move to one of Reed's Medicare plans.

Retirement for those hired on or after July 1, 2006

Employees hired after July 1, 2006, who work at least .5 FTE in a benefits eligible position participate in a different Emeriti retiree medical plan. Under this plan, Reed makes a monthly contribution to a TIAA healthcare account which can be used to pay for any IRS-qualifying medical expense after retirement.

This account remains unvested and unable to be utilized until the employee meets the eligibility requirements (age 55+ and 20 years of service, as above) and becomes a Reed retiree.

Monthly contributions begin once an employee reaches age 40 and they continue for up to 25 years, so long as the employee remains in a benefits eligible position with Reed.

Employees may contribute their own after-tax dollars to this account, subject to IRS limits.

REQUIRED LEGAL INFORMATION

COBRA Rights

If medical, dental, vision, or Health FSA coverage for you or your eligible family members ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child ceasing to meet the definition of “dependent”), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. Domestic Partners are not eligible for COBRA coverage. If you have any questions about your COBRA rights, please read the Initial COBRA Notice, a copy of which has been previously furnished to you and your spouse (if covered). Please contact the Plan Administrator if you need another copy.

The Plan has enacted reasonable procedures for you to notify the Plan Administrator regarding a COBRA Election event as detailed within the Initial COBRA Notice. These reasonable procedures require you to notify the Plan Administrator in writing of any COBRA qualifying event, as detailed within applicable COBRA notice.

Covered employees and qualified beneficiaries are responsible for providing notice of qualifying events, disability and second qualifying events to the Plan Administrator. The notice must be provided within 60 days of the qualifying event or disability. Such notice must be provided in writing to the Plan Administrator, include a description of the qualifying event or disability and the date of the qualifying event or disability occurred.

Health Insurance Portability and Accountability Act Privacy and Security

In the event that a component program is required to comply with HIPAA Privacy and Security obligations, that component program will adopt the required HIPAA Privacy and Security Plan amendments and shall prepare the required disclosure under separate cover. The Health Information Technology for Economic and Clinical Health amendments are included with the component program’s Privacy and Security Plan as applicable.

Medicare Part D

In the event that a component program provides prescription drug coverage either in conjunction with a component program or as a stand-alone component program, the Plan intends to comply with the requirements of Medicare Part D and will notify you of its “Creditable Coverage” status. Such disclosure requirement will be made under separate cover.

Genetic Information Nondiscrimination Act

Notwithstanding anything to the contrary, all component programs shall comply with the Genetic Information Nondiscrimination Act. Based on GINA, in no event shall the Employer make any premium adjustments or adjustments to contributions under any component program based on genetic information; request or require genetic testing; and request, require or purchase genetic information for underwriting purposes.

Qualified Medical Child Support Orders

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order, or “QMCSO” (defined in ERISA § 609(a)), and will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA § 609(c). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Women’s Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Please refer to the insurance company documents listed in Appendix A for these deductibles and coinsurance amounts.

If you would like more information on WHCRA benefits, contact the Plan Administrator. This notice intends to meet the Notice requirements under the WHCRA.

Newborns’ and Mothers’ Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage 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 normal 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 the above periods. In any case, the applicable component benefit programs and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Mental Health Parity Act/Mental Health Parity and Addiction Equity Act

All component benefit programs that are subject to the Mental Health Parity Act/Mental Health Parity and Addiction Equity Act (MHPA/MHPAEA) shall not discriminate against mental health and substance disorder as related to any medical/surgical benefits provided under a component benefit program when such mental health, substance disorder, and medical/surgical benefits are provided. Such discrimination may not occur with regard to the component benefit program's financial requirements or availability of out-of-network treatment under the program's terms and conditions. This provision shall not be valid in the event the Employer makes an election under the cost exemption provisions of the MHPA/MHPAEA.

Michelle's Law

The Plan shall comply with Michelle's Law. Michelle's Law requires that all full-time students who are Dependents participating in this Plan, may take a medical leave of absence from their educational institution for up to one calendar year (limited by the remaining eligibility under this Plan as a Dependent) and may maintain eligibility under this Plan notwithstanding anything to the contrary.

Family Medical Leave Act

If you are eligible to take leave under the Family Medical Leave Act ("FMLA"), you may continue to pay for your medical, dental and vision coverages on an after-tax basis. If the Employer pays a portion of these premiums, it must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of these premiums.

Uniformed Services Employment and Reemployment Rights Act of 1994

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights apply only to eligible employees and eligible dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

- a. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or
- b. For elections made on or after December 10, 2004, the 24 month period beginning on the date that Uniformed Service leave commences;
- c. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage. The Plan has elected reasonable

procedures for you to provide notice of your election of Plan coverage under this provision. These reasonable procedures require that you provide notice of your election of Plan coverage in writing to the Plan Administrator.

A preexisting condition exclusion may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during military service.

Please contact the Plan Administrator for information concerning your eligibility for USERRA and any requirements of the Plan.

Annual Limits

Any annual limits on the dollar value of essential health benefits (as that term is defined by the PPACA and underlying regulations) no longer applies as of March 1, 2014.

Patient Protection

To the extent a medical plan allows the designation of a primary care provider (“PCP”), even if selecting a PCP is not a requirement under the applicable plan:

You have the right to designate any primary care provider who participates in one of our networks and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the respective carriers or visit their websites.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the respective carriers or visit their websites.

WHAT BENEFITS ARE AVAILABLE UNDER THE PLAN?

The Plan provides you with medical, dental, vision, life, STD, LTD, AD&D, a Health Care FSA and retiree coverage. A summary of each benefit provided under the Plan is set forth in the attached certificate of insurance booklet, summary plan description or other governing document referenced in Appendix A. The cost of the benefits provided through the component benefit programs will be funded in part by Employer contributions and in part by post and/or pre-tax employee contributions. The Employer will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Employer will pay its contribution and your contributions to an insurance carrier. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

With respect to component benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws.

HOW IS THE PLAN ADMINISTERED?

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The specified delegate of the Employer is the person who has been designated to act on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Employer will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company

Certain benefits under the Plan are fully insured or provided by contract with a plan administrator. The insurance companies are responsible for determining eligibility and the amount of any benefits payable under the component plans and prescribing claims procedures to be followed and proper forms to be used. The insurance companies are responsible for paying claims with respect to these programs. The Employer shares responsibility with the insurance companies for administering the program benefits.

Questions

If you have any general questions regarding the Plan, or your eligibility for, or the amount of any benefit payable under the self-funded component benefit plans, please contact the Employer, who acts on behalf of the Plan Administrator.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate insurance company.

CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. Your benefits will also cease on termination of the Plan. Other circumstances can result in the termination, reduction or denial of benefits. For example, benefits may be denied under the medical or dental benefit programs if you have a pre-existing condition and incur costs within the exclusionary period. You should consult the certificate of insurance booklets, summary plan descriptions and other governing documents as listed in Appendix A for additional information.

Plan's Right of Subrogation and Reimbursement

If an individual is entitled to or receives benefits under this Plan and is also entitled to or otherwise collects compensation or any other funds from another party (except another benefits Plan maintained by Employer) in connection with that same disability or medical condition, whether by insurance, litigation, settlement, or otherwise, the Plan shall be entitled to such funds to the extent of Plan benefits paid to or on behalf of the individual, whether or not the individual has been "made whole," and without regard to any common fund doctrine, and may recover such funds by constructive trust, equitable lien, right of subrogation, reimbursement, or any other equitable or legal remedy.

If (i) an individual fails, refuses, or neglects to reimburse the Plan or otherwise comply with the requirements of this provision, or (ii) payments are made under the Plan based on fraudulent information or otherwise in excess of the amount necessary to satisfy the provisions of the Plan, then, in addition to all other remedies and rights of recovery that the Plan may have, the Plan shall have the right to terminate or suspend benefit payments and/or recover the reimbursement due to the Plan by withholding, offsetting, and recovering such amount out of any future Plan benefits or amounts otherwise due from the Plan to or with respect to such individual. The Plan shall also have the right in any proceeding at law or equity to assert a constructive trust, equitable lien, or any other equitable or legal remedy or recovery, against any and all persons that have any assets that the Plan can claim rights to. The Plan has the right of first recovery from any judgment, settlement, or other payments, regardless of whether the individual has been "made whole," and without regard to any common fund doctrine.

Anti-Assignment

Health care benefits payable under the applicable component benefit programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person, institution, or otherwise. The Plan or any component benefit program may, at the sole and absolute discretion of the Plan Administrator, pay benefits directly to an institution in which the Participant or Dependent has been admitted as a patient or to any provider of health care services or supplies in consideration for medical or hospital or dental services or supplies rendered or to be rendered regardless of the presence or absence of an assignment of benefits or other form of benefit directive. The Plan or any component

benefit program may also, at the sole and absolute discretion of the Plan Administrator, pay benefit claims directly to a Participant or Dependent regardless of any purported benefit assignment. When benefits are paid directly to a Participant or Dependent, such Participant or Dependent, respectively, is solely responsible for reimbursing the provider. Such payment shall release and discharge the Plan (including the component benefit programs thereunder), Plan Administrator, Employer, and their delegates from any and all liability for all related charges (without regard to whether or not such related charges are otherwise covered under the Plan) for the services or supplies rendered or to be rendered.

No Participant or Dependent may assign to any person, institution, or otherwise his or her right to file a claim and/or an appeal under the Plan's claims and appeal procedures, or to initiate any action or proceeding (legal, equitable, or otherwise) against the Plan (including the component benefit programs thereunder), Plan Administrator, Employer, or their delegates, including, without limitation, a suit for statutory penalties under ERISA for an alleged failure to provide Plan or claim-related documents, with the sole exception of an assignment of the right to appeal an urgent care claim as specifically provided in applicable Department of Labor regulations.

The provisions of this Anti-Assignment section shall not apply to any Employee who is represented by a collective bargaining agent, nor to the Dependent of any such Employee, except to the extent that the terms of the collective bargaining agreement covering such Employee allow for the application of this Anti-Assignment section.

Amendment or Termination of the Plan

The Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Employer or any of its delegates. The Employer may sign insurance contracts for this Plan on behalf of the Employer, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

EXTENT OF INTEGRATION

The underlying component parts of this Plan are integrated for purposes of convenience and ensuring continued compliance, but the function of combining these underlying benefits for compliance purposes in no way undermines the separateness or excepted benefits status that may otherwise exist for certain otherwise excepted benefits provided for under this Plan.

CLAIMS PROCEDURES

Claims for Insured Benefits

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the Plan Administrator is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the attached certificate of insurance booklet for more information about how to file a claim and for details regarding the insurance company's claims procedures.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Employer's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the summary plan description or other governing document behind the applicable Attachments for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

STATEMENT OF ERISA RIGHTS

Your Rights to Receive Information About Your Plan and Benefits

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to examine, without charge, at Reed's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Reed College, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the

court may require Reed College as Plan Administrator, to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the plan, 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 to be frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact Reed College. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution 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.

**REED COLLEGE
EMPLOYEE WELFARE BENEFITS PLAN**

APPENDIX A

Active Employee Benefits

Medical

Kaiser Permanente Northwest
500 NE Multnomah Street
Portland, OR 97232
(503) 813-2000

Dental

Willamette Dental Insurance, Inc.
6950 NE Campus Way
Hillsboro, OR 97124
(855) 433-6825

Kaiser Permanente Northwest
500 NE Multnomah Street
Portland, OR 97232
(503) 813-2000

MetLife
200 Park Ave.
New York, NY 10017
(800) 638-5433

Life/AD&D

Standard Insurance Company
900 SW 5th Ave.
Portland, OR 97204
(800) 628-8600

Long-Term Disability (LTD)

Standard Insurance Company
900 SW 5th Ave.
Portland, OR 97204
(800) 368-1135

EAP

Canopy Inc.
7180 S.W. Fir Loop, Suite 100
Portland, OR 97223
(800) 433-2320

Health FSA

Allegiance Benefit Plan Management, Inc.
2806 S. Garfield St.
P.O. Box 3018
Missoula, MT 59806
(800) 877-1122