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Campbell University, Incorporated

Wrap Summary Plan Description

January 1, 2013

The following information, together with the information contained in the Member Guides furnished by Cigna Insurance, Sun Life Financial Assurance, Reliance Standard Insurance, and AFLAC (Continental American Insurance Company) is intended to make up the Summary Plan Description required by the Employee Retirement Security Act of 1974, §102 (as amended) ("ERISA"), for the portion of benefits administered or insured by Cigna Insurance, Sun Life Financial Assurance, Reliance Standard Insurance, and AFLAC (Continental American Insurance Company).

TABLE OF CONTENTS

	Page
1. Definitions.....	3
2. Introduction.....	5
3. Eligibility and Participation Requirements.....	5
4. Funding and Benefits.....	8
5. Administration and Fiduciary Provisions.....	8
6. Summary of Plan Benefits.....	9
7. Amendment or Termination of the Plan.....	10
8. General Information About the Plan.....	10
9. Employee Rights Under ERISA.....	15
Appendix A. Participating Employers.....	22
Appendix B. Welfare Programs.....	23

1. DEFINITIONS

The following terms used in the Plan have the following meanings:

“AD&D” means Accidental Death & Dismemberment

“CHIPRA” means the Children’s Health Insurance Program Reauthorization Act of 2009.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended.

“Component Benefit Program” or **“Component Benefit Plan”** means each separate benefit program, respectively, which is described in this Summary Plan Description.

“Company” means Campbell University, Incorporated or any successor thereto.

“Effective Date” means January 1, 2013.

“Employee” means any person providing services as a full-time employee working a minimum of 32 hours. The term Employee does not include any person for any period in which such person performs services for Campbell University as an independent contractor or employee of a third party (such as a leasing organization), even if such person is later held to be a common law employee of Campbell University by court or government agency action.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“Former Employee” means any person formerly employed as an Employee.

“GINA” means the Genetic Information Nondiscrimination Act of 2009.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“HSA Plan” means a health savings account tax-savings program for an individual to be reimbursed for out-of-pocket expenses not covered by an individual’s medical, dental, vision or prescription plan or a spouse’s plan.

“Open Access Plan” means you can decide to have your primary care physician refer you to in-network specialists and facilities; it also lets you "self-refer" to in-network specialists and facilities at "discounted rates" or to or out-of-network specialists and facilities at higher out-of-pocket costs.

“Participant” means any Employee or Former Employee who satisfies the requirements of the Eligibility and Participation Requirements.

“Participant Contribution” means the pre- or post-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term “Participant Contribution” includes contributions used for the provision of benefits under a self-insured

arrangement of the Company or a Participating Employer as well as contributions used to purchase insurance contracts or policies.

“Participating Employer” means any member of the following entities that include the Company, if such member adopts the Plan with the Company’s authorization: (i) a controlled group of corporations, within the meaning of Code Section 414(b), (ii) a group of trades or businesses under common control, within the meaning of Code Section 414(c), (iii) an affiliated service group, within the meaning of Code Section 414(m), (iv) a trade or business required to be aggregated pursuant to Code Section 414(o), or (v) a multiple employer welfare arrangement under ERISA. Each Participating Employer is identified in Appendix A.

“Plan” means the Campbell University, Incorporated Group Welfare Benefits Plan, which consists of this document and each Welfare Program incorporated hereunder, as amended from time to time.

“Plan Administrator” means Campbell University, Incorporated unless another entity or person is appointed by Campbell University to administer the Plan.

“Plan Year” means the 12 consecutive month period from January 1 to December 31.

“PPO” is a preferred provider managed care organization of medical doctors, hospitals, and other health care providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

“QMCSO” means a Qualified Medical Child Support Order.

“Spouse” means a marital spouse as determined by North Carolina law.

“Welfare Program” means any of the following written arrangements covered under this Plan that are offered by Campbell University and/or a Participating Employer. Each Welfare Program under the Plan is identified in Appendix B. The separate plan document, or if there is no separate plan document, the summary plan description, describing each Welfare Program is incorporated herein by reference.

- (i) An arrangement that provides any employee benefit that would be treated as one or more “employee welfare benefit plans” under Section 1002(1) of ERISA if offered in the absence of this Plan.

- (ii) An arrangement that is a “cafeteria plan” under Code §125, an “educational assistance plan” under Code §127, a “group legal services plan” under Code §120, a non-ERISA “short term disability plan”, or a “dependent care assistance plan” under §129; provided, however, that such arrangement shall not be treated as subject to the requirements of ERISA solely by reason of the arrangement’s inclusion under this Plan.

2. INTRODUCTION

The Company maintains the Plan for the exclusive benefit of its eligible employees and their eligible family members. The Plan provides benefits through the component benefit programs. This Summary Plan Description contains valuable information regarding eligibility, benefits, and other features of the Plan. The benefits under each of these respective programs are described in the certificate/summary for that program which has been provided to you separately, and is incorporated herein by reference. The providers of the component benefit programs are listed in Section 8, entitled “General Information About the Plan.”

Some of these component benefit programs require you to make an annual election to enroll for coverage. Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company or a summary plan description. A copy of each booklet or summary, which is provided to you under separate cover, is part of this Summary Plan Description and is incorporated herein by reference. This material constitutes the Summary Plan Description for each of the component benefit plans as required by ERISA § 102. The Employer is not an insurer of any of these benefits. This Summary Plan Document does not replace or otherwise modify terms of the Plan. In case of any conflict between this Summary Plan Document and the actual Plan, the Plan shall control.

3. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Employees meeting the following criteria are eligible to participate in the Campbell University, Incorporated Group Welfare Benefit Plan.

Employees and Former Employees who are Participants in a Welfare Program on the Effective Date shall become Participants in this Plan on such date. Thereafter, an Employee and eligible family members shall become a Participant in the Plan when he or she satisfies the eligibility and participation requirements of any Welfare Program. There is no waiting period to apply for enrollment in any of the Benefit Plans. Eligible family members include:

- Legal Spouse
- Dependent child(ren) up to age 26, regardless of student status
- Dependent child(ren) of any age who depend upon the employee for support because of a mental or physical disability

Enrollment must be completed within 30 days of the initial eligibility date in order for an employee to participate in the Plans. Legislative rules dictate that the benefit choices made will remain in effect for the entire plan year, from January 1 to December 31, unless the employee experiences a Qualifying Event. While many of the guidelines relating to eligibility and enrollment are determined by Campbell University, Incorporated and its insurance carriers, the ability to make changes to your benefit plans is governed by the IRS and the Internal Revenue Code. Under the Code you must enroll within a reasonable time period from your eligibility

date. Once you are enrolled you may only make changes to your benefit elections during Open Enrollment or if you have a Qualifying Event that affects the eligibility of you or your dependents, and the requested election change corresponds with the effect on your eligibility.

A Qualifying Event includes:

- A change in your Legal Marital Status such as marriage, death of a spouse, divorce, legal separation, or annulment.
- A change in your Number of Dependents such as birth, adoption, placement for adoption, or death of a child.
- A change in Employment Status such as commencement or termination of employment for you, your spouse, or your dependent; engagement in Family Medical Leave.
- A change in Work Schedule such as a reduction or increase in hours including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse, or your dependent.
- A change in Residence or Worksite for you, your spouse, or your dependent.
- Qualifying for Special Enrollment Rights
- A Change in Cost or Significant Cost Changes for Coverage During the Plan Period
- Addition or Significant Improvement of Benefit Options
- Change of Coverage Under Another Employer's Plan for Employee, Spouse, or Dependent
- The receipt of a Qualified Medical Child Support Order.
- A change in Entitlement to Medicare or Medicaid for you, your spouse, or your dependent.
- A change in Eligibility for COBRA for you, your spouse, or your dependent while you are still an active employee.

All election changes must be requested within 30 days of the event in question. To make an election change, contact the designated Plan Administrator.

Your benefits eligibility may be affected if your status changes from active to inactive due to a family, medical, or personal leave of absence. Please refer to the Campbell University, Incorporated Employee Handbook for details as to how a particular type of leave would affect your benefits eligibility.

Medical and Dental benefits will be terminated on the last day of the month in which full-time active employment ends or the date of an employee's last paycheck. Group Life/AD&D, Short Term Disability, Long Term Disability, Voluntary Life, and Voluntary Accident, Group Accident, Critical Illness, and Cancer benefits will be terminated on the last day of employment.

Fraud or misrepresentation of fact in an application for enrollment or benefits is prohibited. Participation under the Plan shall cease when the Participant ceases to participate in all Welfare Programs or is found to have committed fraud or misrepresented facts as prohibited herein.

Should your benefits be terminated, Federal & State law requires Campbell University, Incorporated, as an employer sponsoring a group health plan, to offer you and your covered dependents the opportunity to elect a temporary extension of health coverage, called

Continuation or COBRA Coverage. You do not have to show that you are insurable to elect continuation coverage. However, you may have to pay all or part of the premium for your continuation coverage. You will receive information from the Company during the open enrollment period each year regarding your annual elections for the coming year. You can find additional information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, in the applicable certificate/summary.

Campbell University complies with the federal Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99 272, and later amendments, otherwise known as COBRA. Covered employees and their dependents who lose insurance coverage for any of the reasons listed below are eligible to continue their coverage through COBRA. All administrative rules and processes as well as changes in plan benefits and premiums apply to those on continuation coverage.

- (a) In the event of divorce or legal separation, or the loss of dependent child status under the plan, a covered employee or dependent must notify Human Resources within 60 days to maintain the right to continue coverage. At that time, Human Resources will provide enrollment materials to the employee or covered dependent within 14 days of that notification.
- (b) The covered employee or dependent has 60 days to elect continuation of coverage from either the date that coverage would ordinarily have ended under the plan by reason of a qualifying event or the date of notification, whichever comes later. Election of continuation of coverage is established by completing and returning enrollment materials to Human Resources.
- (c) COBRA premiums will be billed by the applicable insurance provider, and the first premium will be due within 45 days of the date of election. Subsequent premiums must be received within the terms set forth by the provider. Failure to make timely payments will result in termination of coverage without notice.
- (d) Qualifying Events for Employees:
 - (i) Voluntary or involuntary termination of employment for reasons other than gross misconduct
 - (ii) Reduction in the number of hours of employment
- (e) Qualifying Events for Spouses:
 - (i) Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
 - (ii) Reduction in the hours worked by the covered employee
 - (iii) Covered employee's becoming entitled to Medicare
 - (iv) Divorce or legal separation of the covered employee
 - (v) Death of the covered employee
- (f) Qualifying Events for Dependent Children:
 - (i) Loss of dependent child status under the Plan rules

4. FUNDING AND BENEFITS

The terms of each Welfare Program shall govern the amount and timing of any Participant Contributions and any contributions required to be made by the Company or any Participating Employer. Nothing herein requires the Company, a Participating Employer, or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant or his beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant or beneficiary shall have any right to, or interest in, the assets of the Company or any Participating Employer. Benefits will be paid solely in the form, in the amount, and pursuant to the terms of each Welfare Program.

5. ADMINISTRATION AND FIDUCIARY PROVISIONS

The administration of the Plan is under the supervision 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 Company will bear its incidental costs of administering the Plan.

The Company shall be the “named fiduciary” of the Plan, as defined in section 1102(a)(2) of ERISA, unless the Company appoints a replacement.

Any employee of the Company or a Participating Employer who acts on behalf of the Plan Administrator shall be fully indemnified by the Company and by each Participating Employer against all liabilities, costs, and expenses (including defense costs but excluding any amount representing a settlement unless such settlement is approved by the Company) imposed upon him or her in connection with any action, suit, or proceeding to which it may be a party by reason of having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person’s responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

Each Plan fiduciary shall discharge his duties with respect to the Plan solely in the interest of the Participants and their beneficiaries; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character with like aims.

A fiduciary may serve in more than one fiduciary capacity. A named fiduciary may allocate any of the named fiduciary's responsibilities for the operation and administration of the Plan to other fiduciaries. Either the named fiduciary or other fiduciary appointed by the named fiduciary may employ one or more persons to render advice with regard to any responsibilities such fiduciary has under the Plan.

Unless liability is otherwise provided under Section 1105 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

A claim for benefits under a Welfare Program shall be submitted to the party designated under the claims procedure prescribed under the terms of such Welfare Program.

Any expenses incurred in the administration of the Plan shall be paid by the Company and/or by one or more Participating Employers according to the Company's determination, except to the extent that payment is made from assets of a Welfare Program, which payment shall be permitted to the fullest extent allowed by ERISA.

If you have any general questions regarding the Plan or regarding your eligibility for or the amount of any benefit payable under any of the self-insured component benefit plans, please contact the Human Resources Director/Manager of the Company. If you have any questions regarding your eligibility for, or the amount of, any benefit payable under the insured component benefit plans, please contact the appropriate insurance company. The claims procedures for the component Plan benefits are described in the applicable certificate, which is incorporated into this Summary by reference.

6. SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible family members with medical, prescription drug, dental, short-term disability, long-term disability, employer-provided group term life (which includes accidental death and dismemberment), critical illness, and voluntary accident insurance programs. The Plan also provides you with the opportunity to participate in the Dependent Care Assistance Plan and the Health Care Reimbursement Plan through the Flexible Benefits Plan. As noted above, you have received a summary of each benefit provided under the Plan as set forth in the certificate of insurance or health plan booklet, summary plan description, or other governing document.

As described in more detail in Section 8, “General Plan Information,” the cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by pre-tax or after-tax employee contributions, depending upon the program. The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change the determination at any time. The Company will make its contributions in an amount that (in the Company’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 Company will pay its contributions and your contributions to an insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of you or your eligible family members from the Company’s general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

7. AMENDMENTS OR TERMINATION INFORMATION

The Company, as Plan Sponsor, has the right to amend, modify, suspend or terminate the Plan, or any part of it, at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates.

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

If you bring a liability claim against a third party, benefits payable under the Plan must be included in your claim as well as in any recovery you obtain, either by judgment, settlement, or otherwise, and you must reimburse the Plan Administrator for the full amount of the benefits paid under the Plan. To preserve the Plan’s rights, the Plan Administrator may bring suit in your name or may intervene in any lawsuit you have commenced with a third party.

8. GENERAL PLAN INFORMATION

A. Plan Sponsor

Campbell University, Incorporated
PO Box 595
95 Bolton Rd.
Buies Creek, NC 27506

B. Plan Name

- a) Campbell University, Incorporated Group Health Plan
- b) Campbell University, Incorporated Group Life, Voluntary Life, Voluntary Accidental Death & Dismemberment, Short-Term Disability, and Long Term Disability Plan
- c) Campbell University, Incorporated Group Dental Plan
- d) Campbell University, Incorporated Group Critical Illness Plan
- e) Campbell University, Incorporated Group Accident Plan
- f) Campbell University, Incorporated Flexible Spending Account Plan

C. Type of Plan

- a) Self Insured, Group Health Plan
- b) Fully Insured Group Life, Voluntary Life, Voluntary Accidental Death & Dismemberment, Short-Term Disability, and Long Term Disability Plan
- c) Fully Insured, Group Dental Plan
- d) Fully Insured, Group Critical Illness Plan
- e) Fully Insured, Group Voluntary Accident Plan
- f) Self Insured, Flexible Spending Account Plan

D. Plan Administrator

Campbell University, Incorporated
Attn: James O. Roberts
Vice President for Business and Treasurer
PO Box 97
143 Main St., Room 111
Buies Creek, NC 27506

NOTE: The Plan Administrator has the sole authority and discretion to interpret the terms of the plan. Benefits under the plan will be paid only if the Plan Administrator, or its designee, decides in its sole discretion that the participant is entitled to them.

E. Named Fiduciary

Campbell University, Incorporated

F. Type of Plan Administration

This Plan is administered by Campbell University, Incorporated. Certain administrative duties may be performed by administrative services companies or insurance companies that have entered into contracts with Campbell University, Incorporated.

G. Claims Administrator Information

- a) Cigna Open Access Plus Plan (PPO) and Open Access Plus High Deductible Health Plan (PPO/HSA) (Policy #3336620) is the insurer for group health insurance. Please see the included plan booklet for detailed plan provisions and exclusions.

Medical Claims Filing:

Cigna
P.O. Box 182223
Chattanooga, NC 37422-7223
1-800-224-6224
<http://www.cigna.com>

- b) Sun Life Financial (Policy #203127) is the insurer for Group Employee Life, Voluntary Life, Accidental Death and Dismemberment, and Long-Term Disability benefits under this plan. Please see the included plan booklet for detailed plan provisions and exclusions.

Life and Accidental Death & Dismemberment Claims Filing:

Sun Life Assurance Company of Canada
Group Life Claims, SC 4375
One Sun Life Executive Park
P.O. Box 81365, Wellesley Hills, MA 02481
1-800-247-6875
www.sunlife.com/us

Disability Claims Filing:

Sun Life Assurance Company of Canada
Group LTD Claims, SC 3208
One Sun Life Executive Park
P.O. Box 81830, Wellesley Hills, MA 02481
1-800-247-6875
www.sunlife.com/us

- c) Sun Life Financial (Policy #454-4985-00 & 454-4985-01) is the insurer for Group Dental benefits under this plan. Please see the included plan booklet for detailed plan provisions and exclusions.

Dental Claims Filing:

Sun Life Financial
Employee Benefits Group
PO Box 81633
Wellesley Hills, MA 02481
1-800-451-2513

www.sunlife.com/us

- d) AFLAC (Continental American Insurance Company) (Policy #3682) is the insurer for Critical Illness and Cancer Rider benefits under this plan. Please see the included plan booklet for detailed plan provisions and exclusions.

Critical Illness and Cancer Rider Claims Filing:

AFLAC
Claims Processing Unit
PO Box 427
Columbia, SC 29202
1-800-433-3036
<http://www.aflac.com>

- e) Reliance Standard Insurance Company (Policy #136020) is the insurer for Group Short-Term Disability benefits under this plan. Please see the included plan booklet for detailed plan provisions and exclusions.

Short Term Disability Claims Filing:

Reliance Standard
Attention: Disability Claims
PO Box 7749
Philadelphia, PA 19101-7749
1-800-351-7500
www.rsli.com

H. Type of Funding

Medical and Dental Benefits under the plan are funded by a combination of Employer and Employee contributions, as established by the Plan Administrator. Voluntary Life, Short-Term Disability, Long-Term Disability, Critical Illness, and Voluntary Accident insurance premiums are funded by Employee contributions.

All employee benefit plan contributions designated as Section 125 Cafeteria Plan eligible, will be paid through a pre-tax payroll deduction. All other employee benefit plan contributions will be paid on an after-tax basis. Actual contribution rates will be published during the Campbell University, Incorporated Open Enrollment period in December of each year. The insurance companies, not the Company, are responsible for paying claims with respect to the insured programs. The Company shares responsibility with the insurance companies for administering these program benefits. Insurance premiums for employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees' pre-tax and post-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable.

I. Employer Identification Number

56-0529940

J. Plan Number

501

K. Plan Year

January 1 through December 31

L. Effective Date

January 1 through December 31

M. Agent for the Service of Legal Process

Campbell University, Incorporated
Attn: James O. Roberts
Vice President for Business and Treasurer
143 Main St., Room 111
Buies Creek, NC 27506

N. Collective Bargaining

The Campbell University, Incorporated Group Welfare Benefit Plan is not maintained pursuant to a collective bargaining agreement.

O. Important Disclaimer

Benefits hereunder are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by the Company. 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.

P. Amendment or Elimination of the Group Welfare Benefit Plan

Campbell University, Incorporated reserves the right to amend or terminate the Group Welfare Benefit Plan at any time, in whole or in part. If the Group Welfare Benefit Plan is ever terminated, suspended, or modified, benefits for any service you receive before the change are paid under the Group Welfare Benefit Plan's former conditions, provided that a written notice of claims is timely given. The Group Welfare Benefit Plan does not pay benefits for services received after such action (unless specific provisions are adopted).

9. STATEMENT OF EMPLOYEE ERISA RIGHTS

As a participant in the Campbell University, Incorporated Group Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- You have the right to examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- You have the right to obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- You have the right to receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. SPECIAL ENROLLMENT PERIOD

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause or because premiums were not paid on a timely basis. An Eligible Person and/or Dependent do not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth
- Legal adoption
- Placement of a child in a home for foster care or adoption
- Marriage

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incur a claim that would exceed a lifetime limit on all benefits.

When an event takes place (for example, a birth or marriage), coverage begins on the date of the event if the completed enrollment form and any required Premium are received within 30 days of the event. If additional monthly premiums are not required, a 30-day notice is not required in the event of a newborn, adopted or foster child. For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Coverage will begin only if the completed enrollment form and any required Premium are received within 30 days of the date coverage under the prior plan ended

C. **HEALTH INSURANCE PORTABILITY**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended ERISA to provide for improved portability and continuity of health coverage connected with employment, among other things. The HIPAA portability provisions relating to group health plans and health insurance coverage offered in connection with group health plans are set forth under Part 7 of Subtitle B of Title I of ERISA. These provisions include rules relating to exclusions of pre-existing conditions, special enrollment rights, and prohibition of discrimination against individuals based on health status-related factors.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). HIPAA requires that prior health coverage count toward satisfying the pre-existing limit. The 12-month (or 18 month) exclusion period is reduced by your prior health coverage. However, if

at any time you went for 63 days or more without any coverage a plan may not have to count the coverage you had before the break. You are entitled to a certificate that will show evidence of your prior health coverage. Generally, the previous insurer is required to provide such a certificate to you within 14 days after your prior coverage ends. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without pre-existing condition exclusion. Contact your State Insurance Department for further information.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. If you leave the Company and are covered under a new health plan, check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions. If you need to provide a certificate or other documentation of your previous coverage through the Company, contact the Plan Administrator. You may also request certificates for any of your eligible family members (including your spouse) who were enrolled under your health coverage. The certificate(s) will be provided to you promptly.

D. CONTINUE GROUP HEALTH PLAN COVERAGE (COBRA)

You are eligible to continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your continuation coverage rights. There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

E. ASSIGNMENT OF BENEFITS

You cannot assign, sell or pledge your benefits to another person, or use them as security for a loan. The Plan will not pay benefits to anyone other than you or your covered eligible family members. Several exceptions, however, may apply. For some benefits, such as medical coverage, it is customary for your doctor or other service provider to accept an assignment of benefit payment. In that case, payments will be made on your behalf directly to that doctor or other service provider. The payments

of benefits directly to a health care provider, if any, will be done as a convenience to the covered person and it will not constitute an assignment of benefits under the Plan. When appropriate, the Plan may also withhold taxes from benefit payments. The Plan may also honor tax liens or garnishments against your payments. Finally, the Plan may make deductions from benefits payments to recover previous overpayments or to coordinate benefits with other plans.

F. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

G. ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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.

H. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should

contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

<i>APPLICATION OF OTHER FEDERAL LAWS</i>

A. **NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT OF 1996**

Group health plans and health insurance issuers 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

B. **THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of 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 treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore, the following deductibles and coinsurance apply:

Qualified High Deductible Health Plan

Deductible:

In Network: \$2,000 individual; \$4,000 family

Out of Network: \$4,000 individual; \$8,000 family

Coinsurance:

In Network: 100%

Out of Network: 70%

Out of Pocket Maximum:

In Network: \$2,000 individual; \$4,000 family

Out of Network: \$5,250 individual; \$10,500 family

Traditional PPO Plan:

Deductible:

In Network: \$1,000 individual; \$2,000 family

Out of Network: \$2,000 individual; \$4,000 family

Coinsurance:

In Network: 100%

Out of Network: 50%

Out of Pocket Maximum:

In Network: \$2,000 individual; \$4,000 family

Out of Network: \$4,000 individual; \$8,000 family

C. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan also provides coverage for your child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO). This coverage may apply even if you do not have legal custody of the child, the child is not dependent upon you for support, and regardless of any enrollment period restrictions that might otherwise exist for dependent coverage. Campbell University, Incorporated may withhold from your wages any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice that is issued by a state child support agency, an order, or a judgment from a state court or administrative body directing your employer to cover a child under the Plan. Federal law provides that a medical child support order must meet certain form and content requirements to be valid.

If you are enrolled, you may enroll a child in the Plan pursuant to the terms of a valid QMCSO. If you do not elect an option, the Plan will comply with the QMCSO's terms by providing the default coverage option for the child unless the terms of the QMCSO specify a different option.

D. PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE ACT

In accordance with the provisions of federal law, the Plan does not have separate, lower lifetime maximum caps on mental health benefits with respect to medical coverage under the Plan. The Mental Health Parity Act of 1996 (MHPA) provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. Generally, group health plans offering mental health benefits cannot set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded the protections of MHPA to financial requirements (e.g., copayments or deductibles) or treatment limitations (e.g., visit limits). Any financial requirements or treatment limitations imposed on mental health or substance use disorder benefits can be no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits covered by a plan.

E. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits group health plans and group health insurance issuers from discriminating in health coverage based on genetic information. Plans and issuers may not use genetic information to adjust premium or contribution amounts for the group covered under the plan, request or require an individual or their family members to undergo a genetic test, or request, require, or purchase genetic information for underwriting purposes or prior to or in connection with an individual's enrollment in the plan.

F. CHILDREN'S HEALTH INSURANCE PROGRAM (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires group health plans and group health insurance issuers to permit an employee or dependent that is eligible for but not enrolled in the plan to enroll when the employee or dependent is covered under Medicaid or CHIP and loses that coverage as a result of loss of eligibility or when the employee or dependent becomes eligible for Medicaid or CHIP assistance with respect to coverage under the group health plan. CHIPRA also created new notice requirements related to these special enrollment rights.

APPENDIX A

CAMPBELL UNIVERSITY, INCORPORATED WELFARE BENEFIT PLAN

The following Participating Employers have adopted the Plan:

- **Campbell University, Incorporated**

APPENDIX B

CAMPBELL UNIVERSITY, INCORPORATED WELFARE BENEFIT PLAN

The following Welfare Programs shall be treated as comprising the Plan:

➤ **Campbell University, Incorporated Welfare Benefit Plan**

- **Term Life Insurance and AD&D Plan**
- **Group Long Term Disability Plan**
- **Short Term Disability Plan**
- **Dental Plan**
- **Medical Plan**
- **Critical Illness Policy with Cancer Rider**
- **Long Term Care**
- **Accident Advantage**
- **Flex Spending Account**