SUMMARY PLAN DESCRIPTION

under the

DRAKE UNIVERSITY SECTION 125 PRE-TAX SALARY REDUCTION PREMIUM PAYMENT PLAN

Dated August 2012

Advantage™
ADMINISTRATORS

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INTRODUCTION

Drake University (the "Employer") is pleased to sponsor an employee benefit program known as a "Premium Payment Plan" (the "Plan") for you and your fellow employees. The Employer provides you with the opportunity to pay for your portion of the employee contributions (premiums) for certain benefits on a pre-tax basis. This arrangement helps you because you save Social Security and income taxes on the amount of the premiums you pay.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. This is only a summary of the key parts of the Plan and a brief description of your rights as a Participant (defined in Q-3); it is not a part of the official Plan documents. If there is a conflict between the Plan documents and this Summary Plan Description, the Plan documents will control.

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible Employees (defined in Q-3) to pay for premiums for certain benefits, such as medical and dental insurance, with pre-tax salary reductions.

Q-2. What benefits are provided by the Plan?

The Plan requires an Employee to pay for his or her share of contributions (premiums) for the Plans with pre-tax dollars. "*Insurance Plan"* means the plan providing benefits that your Employer maintains for Employees, their Spouses, Dependents and Employee's non-Dependent children who have not attained age 26 by the end of the calendar year and which your Employer has designated as eligible for pre-tax contributions. Benefits provided under the Plan are called *"Premium Payment Benefits"*. While the Plan permits an Employee to cover Domestic Partners under the Insurance Plan, the portion of the premiums that must be paid to cover these individuals cannot be paid by pre-tax contributions through this Premium Payment Plan per federal law.

Q-3. Who can participate in the Plan?

Employees who satisfy the eligibility conditions for one or more insured benefits under the Insurance Plan are eligible to participate in the Plan, provided that the election procedures in Q-5 are followed.

"*Employee"* means an individual that the Employer classifies as a regular full-time employee and scheduled to work 32 hours or more each week and who is on the Employer's W-2 payroll, except that the term does not include any common-law employee who is a leased employee, or any common-law employee classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee. (A casual employee is an individual who is scheduled to work less than 9 months a year.) "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency

Those Employees who actually participate in the Plan are called "*Participants.*" An Employee continues to participate until (a) the Participant elects during the *Annual Enrollment Period* (defined in Q-6) to discontinue participation in the Plan; (b) the termination of the Plan; (c) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or for any other reason), except that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the current Plan Year); or (d) the Participant revokes his or her election, as described in Q-7.

Q-4. What tax savings would I gain by participating in the Plan?

You save both federal income tax and FICA (Social Security) taxes by participating in the Plan. Following is an example of the tax savings you might experience as a result of participating in the Plan.

Suppose that you pay $6,400 in premiums for your share of health coverage under the plan. You earn $75,000 and your spouse earns no income. You file a joint tax return.

Your annual take-home pay will be $55,977 if you pay for the benefits on an after-tax basis, and $57,427 if you pay for the benefits on a pre-tax basis. (This is because you will be considered for tax purposes to have received $68,600 gross pay, rather than $75,000 with $6,400 contributed to pay for the benefits that you elect.) So, you save $1,450 per year by participating in the Plan. The following Table illustrates this savings.

TABLE OF TAX SAVINGS[1]

		Cafeteria Plan	No Cafeteria Plan
1.	Adjusted Gross Income	$75,000	$75,000
2.	Salary Reduction for Premiums	($6,400)	$0
3.	W-2 Gross Wages	$68,600	$75,000
4.	Standard Deductions	($11,900)	($11,900)
5.	Exemptions	($11,400)	($10,400)
6.	Taxable Income (line 3-4-5)	$45,300	$51,700
7.	W-2 Gross Wages	$68,600	$75,000
8.	Federal Income Tax (line 6@tax schedule)	($5,925)	($6,885)
9.	FICA Tax (7.65% of line 3)	($5,248)	($5,738)
10.	After-Tax Premium Payments	$0	($6,400)
11.	Pay After Taxes and Premium Payments (line 7-8-9-10)	$57,427	$55,977

Q-5. How do I become a Participant?

If you are an Eligible Employee you will become a Participant by electing to receive insurance benefits (and to pay for those benefits by reducing your salary). You must make your benefit election and turn it in to the Employer within the time period specified by the Administrator of the Plan (*Administrator*) and in the form and manner designated by the

[1] The standard deduction, exemptions, federal income tax rates and FICA tax rates are based on taxes for 2012 and can be found in the appropriate IRS and SSA bulletins and publications.

Administrators in the enrollment materials. You will be given the opportunity during the Annual Enrollment Period to elect your coverage for the 12 months beginning on the next June 1, called the "*Plan Year*." A Participant who fails to elect to receive insurance benefits will not be able to participate in the Plan until the next Annual Enrollment Period (unless a *Change in Election Event* occurs, as defined in Q-7). All decisions regarding whether a form was timely and/or proper shall be made by the Administrator.

Q-6. What is the "Annual Enrollment Period"?

You will be notified of the duration of the Annual Enrollment Period.

Q-7. Can I change my election for benefits or salary reduction amounts during the Plan Year?

Generally, you cannot change your election to participate in the Plan (known as the irrevocability rule), except that your election will terminate if you are no longer eligible under the Plan (see Q-8). Of course, you can change your elections for benefits during the Annual Enrollment Period, but that will apply only for the upcoming Plan Year.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events.* "Change in Election Events" include the following events, as more fully described below: Leaves of absence, including FMLA leave (defined in Q-14); Change in Status; certain judgments, decrees and orders; Medicare and Medicaid; Change in Cost; and Change in Coverage. (*Changes in Status, Cost* and *Coverage* are defined below). However, the Change in Election Events do not apply for all Benefits—exclusions are described below for each such Event.

If a Change in Election Event (including a Change in Status) occurs, you must inform the Administrator and complete a new Election Form/Salary Reduction Agreement within 30 days of the occurrence.

1. Leaves of Absence. You may change an election under the Plan upon FMLA leave only as described in Q-14.

2. Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). "*Spouse"* means the person who is legally married to you and is treated as a spouse under the Internal Revenue Code *(Code) (note that the definition of "Spouse" under the Internal Revenue Code may be different than the definition of "Spouse" under applicable state law)*;
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code;
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse, or your Dependents.

Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be eligible for a particular employee benefit;

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age or similar circumstance); and
- a change in your, your Spouse's or your Dependent's place of residence.

3. Change in Status—Other Requirements. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For accident and health benefits, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

    Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change the employee-plus-one-dependent coverage would be consistent with this Change in Status. However, Mike could drop his Health FSA coverage completely.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual

under the Plan would correspond with that Change in Status *only if* coverage for that individual becomes effective or is increased under the other employer's plan.

4. Special Enrollment Rights. If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 *(HIPAA*) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in your Employer's health Insurance Plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect major medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within 30 days after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly-acquired Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Please refer to the summary plan description of the health Insurance Plan for an explanation of special enrollment rights.

5. Certain Judgments, Decrees and Orders. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.

6. Medicare or Medicaid. If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's medical or dental coverage the Plans. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

7. Change in Cost. If the Administrator notifies you that the cost of your coverage under the Plan *significantly* increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the Plan of your Spouse's employer; or (c) drop your coverage, but *only if* there is no option available under the Plan that provides similar coverage. (Note that, for purposes of this definition, (a) the HMO and the PPO are considered to be similar coverage, and (b) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage.) For *insignificant* increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.

> ***Example:*** Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, then Mike may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option. (He cannot drop his indemnity coverage without electing coverage under the HMO, because the HMO is a benefit package option that provides similar coverage.)

8. Change in Coverage. You may also change your election for the Plan if one of the following events occurs:

- *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of coverage (for example, the HMO ceases to be available where you live), then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the Plan of your Spouse's employer, or drop coverage but *only if* there is no option available under the plan that provides similar coverage.
- *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the health Insurance Plan.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

Additionally, the Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease. See Q-12 and the booklets for the Insurance Plan for information on your right to continued or converted group health coverage after termination of your employment.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a change in your employment status, you will become eligible to participate again in the Plan immediately upon re-satisfying the eligibility requirements.

Q-9. Will I pay any administrative costs under the Plan?

All expenses incurred in administering the Plan are currently paid by the Employer.

Q-10. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if my claim for benefits is denied?

Insurance Plan Claims. If your claim is for a benefit under an insurance policy offered under the Insurance Plan, you will generally proceed under the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for that plan or policy.

Claims Under the Plan. However, if you are denied a benefit under this Plan due to an issue germane to your coverage under the Plan (for example, a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Premium Payment Plan Document), then the claims procedure described below in this Q-11 will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Administrator within 30 days of the date the Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Administrator is expected to be made. Where a claim is incomplete the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appeals by Participant. If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Administrator. Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your

claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decisions on Review. Your appeal will be reviewed and decided by the Administrator or his/her designee or other entity designated in the Plan in a reasonable time upon receipt of you request for review. If the decision on the review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

a. the specific reason(s) for the decision on review;
b. the specific Plan provision(s) on which the decision is based;
c. a statement of your right to review (upon request and at no charge) relevant documents and other information;
d. if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
e. a statement of your right to bring suit under ERISA § 502(a) (where applicable).

Q-12. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your Spouse's and Dependents' right, to continue the same coverage under any component medical benefit plan that was in place the day before a *Qualifying Event* if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of such Qualifying Event. Continuation coverage under federal law is provided under *COBRA* (Consolidated Omnibus Budget Reconciliation Act of 1985) if your Employer is subject to COBRA.

A Qualifying Event is:

- termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- your death;
- divorce or legal separation from your Spouse;
- your becoming entitled to receive Medicare benefits; or
- your dependent's ceasing to be a dependent.

For a Qualifying Event other than a change in your employment status or death, it will be your obligation to inform the Administrator of the qualifying event within 60 days of its occurrence. The Administrator, in turn, will furnish you (and your Spouse, as the case may be) with separate, written options to continue the coverages provided at stated premium costs with respect to each health plan in which you are participating. The notification you receive will explain the terms and conditions of the continued coverage.

Q-13. How will participating in the Plan affect my Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension,

disability and life insurance), which are based on taxable compensation. However, the tax savings that you realize through Plan participation will normally more than offset any reduction in other benefits.

Q-14. How do FMLA leaves of absence affect my benefits?

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your health insurance benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the premium to the extent you opt to continue coverage). Your Employer may elect to continue all health insurance benefits for Participants while they are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and you opt to continue your health insurance benefits, then you may pay your share of the premium in one of two ways: (1) with after-tax dollars while on leave; or (2) with pre-tax dollars to the extent you receive compensation during the leave, or by pre-paying all or a portion of your share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days. (To pre-pay in advance, you must make a special election before such compensation would normally be available to you.) Note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year.

If your health insurance benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be entitled to re-enter such benefits upon return from such leave on the same basis as you were participating in the Plan before the leave, or otherwise required by the FMLA. You are entitled to have coverage for such benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

Q-15. What are my "Premium Payment Benefits"?

If you elect insurance coverage, you will be required to pay for your share of insurance premiums with pre-tax dollars. This means that the share of the premiums you pay will be paid with pre-tax funds, which saves you Social Security and income taxes on the amount of your salary reduction. Contact your Employer for a list of the Insurance Plan benefits offered under your Plan.

Q-16. How are my Premium Payment Benefits paid?

If you elect insurance coverage, you must pay any premium for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, unless otherwise agreed with, or as deemed appropriate by the Administrator). The Employer will not be liable to you if any insurance company fails to provide any of the insurance benefits.

The Employer may contribute all, some or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Q-17. What are my ERISA Rights?

This Premium Payment Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (*ERISA*). However, the Insurance Plan is governed by ERISA. As a Participant in an ERISA-covered benefit plan, you are entitled to certain rights and protections under ERISA.

Your Rights. 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 participants shall be entitled to:

- Examine, without charge, at the administrator'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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the 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.
- Receive a summary of the Plan's annual financial report, if any. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You have a right to continue your health Insurance Plan coverage for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You have rights regarding reduction or elimination of exclusionary periods of coverage for preexisting 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 COBRA continuation coverage, when your COBRA 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 a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action 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 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 you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (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 the Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights you may seek assistance from the U.S. Department of Labor, or you may file a suit in a federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions. If you have any questions about your plan, you should contact the Administrator. 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 administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

Q-18. What other general information should I know?

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

General Plan Information

- Drake University Section 125 Pre-Tax Salary Reduction Premium Payment Plan is the name of the Plan.
- The Plan Sponsor has assigned Plan Number 503 to your Plan.
- The provisions of the Plan described in this Summary Plan Description became effective on June 1, 2011. The Plan was originally effective on June 1, 2001.
- Your Plan's records are maintained on a 12-month period of time. This is known as the Plan Year. The Plan Year begins on June 1 and ends on May 31. The date of the end of the year for maintaining the fiscal year plan records is May 31.
- This is a welfare plan. Therefore, your benefits are not insured by the Pension Benefit Guaranty Corporation (PBGC), an agency of the federal government. The PBGC generally requires or provides insurance for certain pension plans only.

Plan Sponsor Information

- The Plan Sponsor's name and address are:

Drake University
2507 University Avenue
Des Moines, IA 50311

- The Plan Sponsor's federal employee tax identification number (EIN) is 42-0680460.

Plan Administrator Information

- The Plan Sponsor is the Plan Administrator.

Service of Legal Process

The Plan Sponsor is the Plan's agent for service of legal process. Legal process can be serviced on the Plan Sponsor at the address listed above.

Qualified Medical Child Support Order

This Plan extends benefits to a Participant's non-custodial child, as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). 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 Administrator.

Newborns' and Mothers' 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Plan Documents

This Summary Plan Description does not describe the Benefits Plans for which pre-tax benefits are authorized. Consult the Plan documents and the separate Summary Plan Descriptions for descriptions of the benefits provided under these Benefit Plans.