Kalamazoo College
Kalamazoo College
1200 Academy Street
Kalamazoo, MI 49006

Kalamazoo College Wrap Plan

Summary Plan Description

Amended and Restated July 01, 2017
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I. SUMMARY PLAN DESCRIPTION SUPPLEMENT

This document and the certificates issued with respect to the Welfare Programs described herein (the "Certificates") together comprise the Summary Plan Description (SPD) for the Kalamazoo College Wrap Plan (the "Plan"). If the terms of this document conflict with the terms of the Certificates, then the terms of the Certificates will control, unless otherwise required by law.

The SPD summarizes your rights and obligations as a participant (or beneficiary) in the Plan. It is intended to comply with the minimum federal legal requirements for SPDs. To the extent any greater legal rights are afforded to you by the Plan or any applicable state law not pre-empted by ERISA, those legal rights supersede the rights set forth in the SPD.

GENERAL INFORMATION

NAME OF PLAN:

Kalamazoo College Wrap Plan

PLAN SPONSOR:

Kalamazoo College
1200 Academy Street
Kalamazoo, MI 49006

The Plan Sponsor is sometimes referred to as the "Company."

EMPLOYER IDENTIFICATION NUMBER:

38-1358014

PLAN NUMBER:

525

PLAN ADMINISTRATOR:

Kalamazoo College
1200 Academy Street
Kalamazoo, MI 49006

TYPE OF PLAN:

Kalamazoo College Wrap Plan including Medical, Dental, Life, Disability and Vision benefits.

PLAN YEAR:

The current Plan Year is a shortened year that begins on July 01 and ends on
December 31. The following Plan year will be a full 12 month period that begin on January 01, 2018 and end on December 31, 2018.

CLAIMS ADMINISTRATION:

Claims for benefits are administered by the respective companies set forth at Appendix A that include but are not limited to: Medical, Dental, Life, Disability and Vision.

AGENT FOR SERVICE OF LEGAL PROCESS:

Kalamazoo College
1200 Academy Street
Kalamazoo, MI 49006

You may also serve legal process on the Plan Administrator or any successor in title or office of the current registered agent of the company.

TYPE OF ADMINISTRATION:

Some benefits under the Plan are fully insured and are paid pursuant to the terms of insurance policies issued by insurance companies.

Other benefits are self-funded and are paid from the general assets of the Sponsor. The Sponsor has entered into contracts with third party vendors to assist the Sponsor in administering self-funded benefits.

ELIGIBILITY:

The eligibility and participation requirements for each Welfare Program are stated in the applicable Policy or Welfare Program document. Where the eligibility and/or participation requirements are not stated in the Policy or Welfare Program document, the eligibility and/or participation requirements stated in this SPD and the Plan Document shall control, as otherwise set forth below:

You will be eligible to participate in the Plan if you are a full-time employee regularly scheduled to work at least 20 hours per week ("full-time Employee").

You will enter the plan on the same day that you are eligible to enter your employer’s group medical plan.

A reemployed former Participant shall again be eligible to become a Participant in the Plan when the Participant again satisfies the requirements set forth in the Section titled: "Eligibility and Participation".

AMENDMENT AND TERMINATION:

The Kalamazoo College Wrap Plan (the "Plan Document") contains all the terms of the Plan and may be amended from time to time at its sole discretion by your Employer. Any changes made shall be binding on each Covered Participant and any other Covered Persons referred to in the Plan Document.

The Booklet will disclose any Plan provisions governing your benefits, rights and obligations upon plan termination or the amendment or elimination of benefits under the Plan.
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 companies listed below to the effect that you will be employed for any specific period of time.

BENEFITS AND ADMINISTRATION:

The Plan provides benefits for eligible employees and covered dependents as administered under policies of insurance as listed in Appendix A that include but are not limited to: Medical, Dental, Life, Disability and Vision. These Welfare Programs are insured or administered by the companies also listed in Appendix A and are generally described in the Plan Document. The administrative functions include paying claims and determining medical necessity.

Replacements for lost or misplaced copies of the Plan Document may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

Please refer to the Plan Document for a description of the circumstances that may result in disqualification, ineligibility, or the denial, loss, forfeiture, suspension, offset, reduction, or subrogation of benefits.
II. SUMMARY OF PLAN BENEFITS

The Plan provides you and your eligible dependents with the coverages summarized in Appendix A. A summary of the benefits provided under the Plan is set forth in the certificates issued by the insurance companies.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT:

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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

WOMEN'S HEALTH CANCER RIGHTS ACT:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (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:

1. All stages of reconstruction of the breast upon which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits under this Plan.

LOSS OF BENEFITS:

The provisions regarding termination of coverage and limitations and exclusions of benefits that may result in reduction or loss of benefits are explained in the Welfare Benefit Booklet.

CONTRIBUTIONS:

Contributions to the Plan are provided by the Employer and Employees. Employee contributions are made via automatic payroll deductions. The Plan Administrator will provide a schedule of the applicable premiums during open enrollment periods and upon request.
HOW TO RECEIVE YOUR BENEFITS:

This information is explained in the article entitled "CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS" or "CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA" as the case may be.

BENEFIT-SPECIFIC INFORMATION:

Please refer to the appropriate insurance policies and/or summaries of coverage for the following information:

- A description of any cost-sharing provisions (such as premiums, deductibles, coinsurance, and copayment amounts) for which you or a beneficiary will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventative services are covered under the Plan;
- Whether, and under what circumstances, existing and new drugs are covered under the Plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers;
- The composition of the provider network, and whether and under what circumstances coverage is provided for out-of-network services;
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.
III. CLAIMS PROCEDURE FOR PPACA EXEMPT PLANS

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. To the extent that a claims procedure is not prescribed for a self-funded Welfare Program, and the self-funded Welfare Program is not subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such self-funded Welfare Program. If the self-funded Welfare Program is subject to PPACA, the claims procedure applicable to such self-funded Welfare Program is described in the section entitled “Claims Procedure for Plans Subject to PPACA.”

A "claim" is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. A claim shall be filed in writing with the Claims Administrator and decided within 90 days (45 days in the case of a disability claim) by the Claims Administrator (unless special circumstances require an extension of up to 90 additional days [up to 30 additional days in the case of a disability claim]). Written notice of the decision on such claim shall be furnished promptly to the claimant. If the claim is wholly or partially denied, such written notice shall: (1) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Welfare Program documents; (2) describe any additional information or material needed to support the claim and explain why such information or material is necessary; and (3) describe the review procedures in subsection (b).

2. A claimant may review all pertinent documents and may request a review by the Claims Administrator of such decision denying the claim. Any such request must be filed in writing with the Claims Administrator within 60 days (or 180 days in the case of a disability claim) after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information that the claimant wishes the Claims Administrator to consider.

Written notice of the decision on review shall be furnished to the claimant within 60 days (45 days in the case of a disability claim) (or 120 days [90 days in the case of a disability claim] if special circumstances warrant an extension) following the receipt of the request for review. The written notice of the Claims Administrator's decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or Welfare Program on which the decision is based, and a statement of the claimant's right to bring suit under ERISA (where applicable). Such suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within 90 days after the final
decision is provided; or if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical necessity determination prior to receiving care, the Claims Administrator (as defined in the Plan) will notify the covered person of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond the Claims Administrator's control, the Claims Administrator will notify the individual of this fact within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice or 45 days after the covered person's receipt of the notice, whichever is sooner.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person’s health condition, would cause severe pain which cannot be managed without the requested services, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator will notify the covered person of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request, specifying what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time, not to exceed 48 hours. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the covered person fails to follow the Claims Supervisor’s procedures for requesting a pre-service medical necessity determination, the Claims Administrator will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program) such reduction or termination constitutes an adverse benefit determination. The Claims Administrator shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.
When an ongoing course of treatment to be provided over a period of time or number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator’s control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person’s receipt of the notice, whichever is sooner.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan or Welfare Program provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

5. **Appeal of Denied Claim.**

1. **First Level of Appeal.** If a covered person’s claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person’s circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed.
differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

The Claims Administrator's review will be processed in accordance with the following time frames:

1. 72 hours in the case of an urgent care claim;

2. 30 days in the case of a pre-service claim;

3. before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment;

4. 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or

5. 60 days in the case of a post-service claim.

2. Second Level Of Appeal. If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator's final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

The Employer may require submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law. A deemed exhaustion, however, does not occur if violations of the claims review process are de minimis, violations that do not cause, and are not likely to cause prejudice or harm to the claimant so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between the claimant and the Plan Administrator, claims administrator or Named Fiduciary.

6. Notice of Benefit Determination on Appeal. Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2)
reference to the specific Plan or Welfare Program provisions on which the
determination is based; (3) a statement that the individual is entitled to receive,
upon request and free of charge, reasonable access to and copies of all
documents, records, and other Relevant Information (as defined below); (4) a
statement describing any voluntary appeal procedures offered by the Plan and any
claimant’s right to bring an action under ERISA Section 502(a); (5) upon request
and free of charge, a copy of any internal rule, guideline, protocol or other similar
criterion that was relied upon in making the adverse determination regarding the
appeal, and an explanation of the scientific or clinical judgment for a determination
that is based on a medical necessity, experimental treatment or other similar
exclusion or limit; and (6) a statement that claimant may have other voluntary
alternative dispute resolution options such as mediation and that one way to find
out what may be available is to contact the local U.S. Department of Labor office
and state insurance regulatory agency.

Any action under ERISA Section 502(a) may be filed only after the Plan’s review
procedures described above have been exhausted and only if the action is filed
within 90 days after the final decision is provided.

Relevant Information is any document, record, or other information which (a) was
relied upon in making the benefit determination; (b) was submitted, considered, or
generated in the course of making the benefit determination, without regard to
whether such document, record, or other information was relied upon in making the
benefit determination; (c) demonstrates compliance with the administrative
processes and safeguards required by federal law in making the benefit
determination; or (d) constitutes a statement of policy or guidance with respect to
the Plan concerning the denied treatment option or benefit for the claimant’s
diagnosis, without regard to whether such advice or statement was relied upon in
making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will
apply:

1. No deference will be afforded to the initial adverse determination;

2. The review will be conducted by an appropriate named fiduciary who is
   neither the individual who made the adverse benefit determination that is the
   subject of the appeal, nor the subordinate of such individual;

3. In deciding an appeal that is based in whole or in part on a medical judgment,
   the fiduciary shall consult with a health care professional who has
   appropriate training and experience in the field of medicine involved in the
   medical judgment;

4. Any medical or vocational experts whose advice was obtained on behalf of
   the Plan in connection with an adverse determination will be identified,
   without regard to whether the advice was relied upon in making the
determination;

5. Any health care professional consulted in making a medical judgment shall
   be an individual who was neither consulted with in connection with the
   adverse determination that is the subject of the appeal, nor the subordinate
   of any such individual; and
6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.
IV. CLAIMS PROCEDURE FOR PLANS SUBJECT TO PPACA

A claim for benefits under a Welfare Program must be submitted in accordance with the claims procedure prescribed for the applicable Welfare Program. **To the extent that a claims procedure is not prescribed for a Welfare Program, and the Welfare Program is subject to the Patient Protection and Affordable Care Act ("PPACA"), the claims procedure described in this section shall apply with respect to such Welfare Program.** If the Welfare Program is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the section entitled “Claims Procedure for PPACA Exempt Plans.”

A “claim” is defined as any request for a plan benefit made by a claimant (or by an authorized representative of a claimant) that complies with the Plan procedures for making a benefit claim. The times listed are maximum times only. A period of time begins at the time the claim is filed. "Days" means calendar days, not business days.

There are different types of claims (including Disability, Pre-Service, Concurrent and Post-Service), and each one has specific timetables for approval, payment, request for further information, and denial of the claim.

NON-GROUP HEALTH & DISABILITY CLAIMS PROCEDURES:

1. A claim shall be filed in writing with the Claims Administrator, and shall be decided within 90 days (45 days in the case of a disability claim) by the Claims Administrator (unless special circumstances require an extension of up to 90 additional days [up to 30 additional days in the case of a disability claim]). Written notice of the decision on such claim shall be furnished promptly to the claimant. If the claim is wholly or partially denied, such written notice shall: (1) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Welfare Program documents; (2) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary; and (3) describe the review procedures in the next section.

2. A claimant may review all pertinent documents and may request a review by the Claims Administrator of such decision denying the claim. Any such request must be filed in writing with the Claims Administrator within 60 days (or 180 days in the case of a disability claim) after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information that the claimant wishes the Claims Administrator to consider.

Written notice of the decision on review shall be furnished to the claimant within 60 days (45 days in the case of a disability claim) (or 120 days [90 days in the case of a disability claim] if special circumstances warrant an extension) following the receipt of the request for review. The written notice of the Claims Administrator's decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or Welfare Program on which the decision is based, and a statement of the claimant's right to bring suit under ERISA (where applicable). Such suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within 90 days after the final decision is provided, or if a later date is specified in a booklet, certificate or other
documentation for a particular Welfare Program, such later date with respect to a
claim arising out of that Welfare Program.

GROUP HEALTH CLAIMS PROCEDURES:

1. **Pre-Service Claim Determinations.** When a covered person requests a medical
necessity determination prior to receiving care, the Claims Administrator will notify
the covered person of the determination within 15 days after receiving the request.
However, if more time is needed due to matters beyond the Claims Administrator's
control, the Claims Administrator will notify the individual of that fact within 30 days
after receiving the request. This notice will include the date a determination can be
expected. If more time is needed because necessary information is missing from
the request, the notice will also specify what information is needed, and the
covered person must provide the specified information to the Claims Administrator
within 45 days after receiving the notice. The determination period will be
suspended on the date the Claims Administrator sends such a notice of missing
information, and the determination period will resume on the date the covered
person responds to the notice or 45 days after the covered person's receipt of the
notice, whichever is sooner.

If the determination periods above involve urgent care services, or in the opinion of
a physician with knowledge of the covered person's health condition, would cause
severe pain which cannot be managed without the requested services, the Claims
Administrator will make the pre-service determination on an expedited basis. The
Claims Administrator will notify the covered person of the expedited determination
within 72 hours after receiving the request. However, if necessary information is
missing from the request, the Claims Administrator will notify the individual within
24 hours after receiving the request specifying what information is needed. The
covered person must provide the specified information to the Claims Administrator
within a reasonable amount of time not to exceed 48 hours. The Claims
Administrator will notify the individual of the expedited benefit determination within
48 hours after the individual responds to the notice. Expedited determinations may
be provided orally, followed within 3 days by written or electronic notification.

If the covered person fails to follow the Claims Supervisor's procedures for
requesting a pre-service medical necessity determination, the Claims Administrator
will notify the individual of the failure and describe the proper procedures for filing
within 5 days (or 24 hours, if an expedited determination is required, as described
above) after receiving the request. This notice may be provided orally, unless the
covered person requests written notification.

2. **Concurrent Claim Determinations.** When an ongoing course of treatment, to be
provided over a period of time or number of treatments, has been approved for a
covered person and there is a reduction or termination of such course of treatment
(other than by the amendment or termination of the Welfare Program) such
reduction or termination constitutes an adverse benefit determination. The Claims
Administrator shall notify the claimant of such reduction or termination at a time
sufficiently in advance of the reduction or termination to allow the claimant to
appeal and obtain a determination on review before the benefit is reduced or
terminated.

When an ongoing course of treatment to be provided over a period of time or
number of treatments has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Administrator will notify the covered person of the determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receiving the request.

3. **Post-Service Claim Determinations.** When a covered person requests a claim determination after services have been rendered, the Claims Administrator will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Supervisor will notify the individual of that fact within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice or 45 days after the covered person's receipt of the notice.

4. **Notice of Adverse Determination.** Every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, as required by law, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (8) The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

5. **Appeal of Denied Claim.**

   1. **First Level of Appeal.** If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims
Administrator. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person’s circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Administrator immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Administrator will issue a decision on review.

The Claims Administrator’s review will be processed in accordance with the following time frames: (a) 72 hours in the case of an urgent care claim; (b) 30 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 60 days in the case of a post-service claim.

2. **Second Level Of Appeal.** If, after exhausting the first level appeal with the Claims Administrator, a claimant is still not satisfied with the result, he or she (or the claimant’s designee) may appeal the claim directly to the Employer. Appeals will not be considered by the Employer unless and until the claimant has first exhausted the appeal procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Administrator’s final decision on review. As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim.

The Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

The Employer’s decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth above.

After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article VII, a claimant will be deemed to have exhausted the Plan’s internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

6. **Notice of Benefit Determination on Appeal.** Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to
receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) a statement that claimant may have other voluntary alternative dispute resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office or state insurance regulatory agency.

Any action under ERISA Section 502(a) may be filed only after the Plan’s review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

"Relevant Information" is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7. **Review Procedures on Appeal.** In the conduct of any review, the following will apply:

1. No deference will be afforded to the initial adverse determination;

2. The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

3. In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;

5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual;

6. In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be
submitted orally or in writing by the claimant, and (b) all necessary
information, including the Plan’s determination on review, shall be submitted
between the Plan and the claimant by telephone, facsimile or other available
similarly expeditious method; and

7. The claimant will be provided with any new or additional evidence
considered, relied upon, or generated by the Plan in connection with the
claim, as well as any new or additional rationale for denial. The claimant will
have a reasonable opportunity to respond to such new evidence or rationale.

8. **External Claims Procedure.** After receiving notice of an adverse benefit
determination or a final internal adverse benefit determination, a claimant may file
with the Plan a request for an external review, except that a denial, reduction,
termination, or a failure to provide payment for a benefit based on a determination
that a claimant or beneficiary fails to meet the requirements for eligibility under the
Plan is not eligible for the external review process. A claimant may request from the
Plan Administrator additional information describing the Plan’s external review
procedure.
V. WHEN COVERAGE MAY BE CONTINUED

You and your covered dependents may continue your medical coverage under this Plan under certain circumstances, according to the terms of your employer’s Leave of Absence Policy, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment And Reemployment Rights Act (USERRA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA). Medical coverage for yourself and your covered dependents may be continued if you cease active work because of an approved medical, family, personal, or military leave of absence or if your employment with the Company ends.

COBRA CONTINUATION OPTIONS:

To the extent a description of COBRA rights is not provided for a Welfare Program, the following applies:

What is COBRA continuation coverage?

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

Are there other coverage options?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (the "Marketplace"). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. Please note that certain excepted benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

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

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

The term "Covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan. However, this provision does not establish eligibility for these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

What is a Qualifying Event?

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

1. The death of a Covered Employee.

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a Covered Employee's employment.

3. The divorce or legal separation of a Covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

4. A Covered Employee's enrollment in any part of the Medicare program.
5. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Covered Employee, or the covered spouse or a dependent child of the Covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a Covered Employee, or the spouse, or a dependent child of the Covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

**What factors should be considered when determining to elect COBRA continuation coverage?**

When considering options for health coverage, Qualified Beneficiaries should consider:

Premiums. This plan can charge up to 102% of the total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under "Are there other coverage options?" for more information on your options for Marketplace coverage.

**What is the election period and how long must it last?**

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.
The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

Is a Covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

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

1. the end of employment or reduction of hours of employment,
2. death of the Employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or
4. the Employee's entitlement to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (e.g., divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60 day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.
NOTICE PROCEDURES:

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

Kalamazoo College
1200 Academy Street
Kalamazoo, MI 49006

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

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

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

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

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary’s election rights?

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do
so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?**

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

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

5. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

   1. 29 months after the date of the Qualifying Event or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

   2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

**What are the maximum coverage periods for COBRA continuation coverage?**

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

1. In the case of a Qualifying Event that is a termination of employment or reduction of
hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a Covered Employee's entitlement to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Covered Employee ends on the later of:

   1. 36 months after the date the Covered Employee becomes entitled to Medicare; or

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

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

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

**Under what circumstances can the maximum coverage period be expanded?**

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

**How does a Qualified Beneficiary become entitled to a disability extension?**

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

**Does the Plan require payment for COBRA continuation coverage?**

For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the
applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?**

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

**What is Timely Payment for COBRA continuation coverage?**

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan at a later date is also considered Timely Payment if either (i) under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed to make the payment until that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed to pay for coverage of similarly situated non COBRA beneficiaries for the period in question until that later date.

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

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

**Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?**

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

**For more information**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA)
website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

FAMILY AND MEDICAL LEAVE ACT:

Except to the extent otherwise provided in the appropriate insurance policies and/or summaries of coverage, the provisions provided in this document with respect to the Family and Medical Leave Act of 1993 (FMLA) will apply. If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave each year for certain specified family and medical reasons under the FMLA. Upon your return to work after FMLA leave, you will be entitled to the position that you held when your FMLA leave began or an equivalent position with equivalent pay, benefits and other terms and conditions of employment.

Under certain circumstances, when restoration of employment would cause substantial and grievous economic injury to the Company’s operations, certain highly paid “key” employees may not be reinstated after FMLA leave.

You must notify your Plan Administrator at least 30 days before the beginning of your leave if the leave is foreseeable. If the leave is not foreseeable, you must provide such notification as soon as possible. Please contact the Plan Administrator to determine whether you qualify for FMLA leave.

If you take leave under FMLA, you will be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you marry or have or adopt a child (or you otherwise acquire a new dependent) during your leave, your new spouse or dependent will also be eligible for coverage during your leave (if you continued your coverage under the Plan and such spouse or dependent meets the plan’s eligibility requirements). You will be responsible for paying your portion of these benefits at active employee rates while you are on leave. You will be required to pay your contributions for your benefits on a monthly basis (with after-tax dollars) in the manner required by the Company. Please contact your Plan Administrator for more information.

You will be eligible for new benefits that are offered by the Company during your leave. Your coverage will also be affected by any changes that the Company makes to the benefit plans and programs during your leave. If the costs for providing new or changed benefits increase during your leave, your contributions may increase accordingly.

When you return from your FMLA leave, you will continue your benefits in accordance with your coverage elections that were in effect immediately before your leave. You will be able to make coverage elections that differ from those that were in effect before your leave only if there is an annual open enrollment period at that time or you have a life change event.

FMLA and leave to care for a service member

If you need to care for a family member who was injured or became ill while on active military duty, you may be entitled to up to 26 weeks of FMLA leave. Additionally, unpaid active duty leave may also be available. Any leave related to military duty or military illness or injury will be administered in accordance with applicable federal requirements.
Caregiver leave

Caregiver leave, which is unpaid, will be granted to you in the event that you are needed to care for a family member who is an Armed Forces service member recovering from a serious illness or injury. If you are the spouse, son, daughter, parent, or nearest blood relative of a service member who is medically unfit to perform the duties of his or her office, grade, rank or rating, and the service member is undergoing medical treatment, recuperation, or therapy, is in an outpatient status, or is on the temporary disability retired list, you may take job-protected leave in order to care for the service member.

Caregiver leave will not be provided in addition to FMLA leave taken for other reasons, and the 26-week caregiver leave may only be taken in a single 12-month period.

Active Duty leave

If you are eligible for FMLA leave, active duty unpaid leave (when required by the government) will be granted if a family member has been called up to or engaged in active military duty. Under the active duty leave provision, the Company will grant up to 12 weeks of FMLA leave. This leave will be granted for events outlined in regulations, and the leave will be available if your spouse, son, daughter, or parent is on or is called into active duty against another military force. If you request this leave you must provide the Company with notice as soon as it is "reasonable and practicable" and you may be required to provide certification supporting the active duty of the affected family member.

If you have any questions regarding whether FMLA leave applies to you, you should contact your human resources office.

CONTINUATION OF COVERAGE UNDER USERRA:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of health care coverage for employees called for active duty military service.

Except to the extent greater benefits are provided under the terms of the appropriate insurance policies and/or summaries of coverage, the maximum length of extended coverage under USERRA is the lesser of:

1. 24 months beginning on the date that the military leave begins; or

2. A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a
result of the military service.

COBRA continuation coverage and USERRA continuation coverage are concurrent.
VI. QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan. A QMCSO may apply to coverage under the Plan. Once the Plan Administrator determines that the order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Plan Administrator receives a QMCSO, you and the affected child will be notified by the Plan Administrator before benefits are assigned pursuant to the order.
VII. SUBROGATION & RIGHT OF REIMBURSEMENT

The provisions of this section pertaining to subrogation shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to subrogation, or (ii) a court, arbitrator, mediator or other judicial body determines that the subrogation provisions of a Welfare Program are not enforceable. The provisions of this section pertaining to a right of reimbursement shall apply in the event that (i) a Welfare Program does not provide provisions pertaining to a right of reimbursement, or (ii) a court, arbitrator, mediator or other judicial body determines that the right of reimbursement provisions of a Welfare Program are not enforceable.

If a covered person becomes sick or injured and has the right to receive benefits under this Plan, but also has the right to receive compensation for the sickness or injury from a third party (such as an insurance company, for example), the Plan, or the Plan’s designee, has a right of recovery.

The Plan’s right of recovery includes the right to be reimbursed from any payment by the third party for the covered person’s sickness or injury, for Plan benefits paid with respect to the sickness or injury. The Plan’s right of recovery also includes the right of subrogation which means that the Plan can choose to assert the covered person’s right of recovery against the third party. The Plan’s right of recovery extends to any right of recovery the covered person’s estate, spouse, dependents, guardian or other representative may have against the third party.

The Plan will have a first priority lien on any full or partial recovery by or on behalf of the covered person from the third party. The covered person (and the covered person’s personal representative, beneficiary, or estate) shall agree to reimburse the Plan in full, and in first priority, for benefits paid by the Plan relating to the sickness or injury. The covered person (or the covered person’s personal representative, beneficiary, or estate) shall serve as a constructive trustee over the funds due and owed to the Plan and hold such funds in trust.

The Plan’s right of recovery will apply regardless of whether the covered person is made whole from the recovery against the third party, and will not be reduced or prorated by or on account of the covered person’s attorneys’ fees and costs. Any full or partial recovery by the covered person against a third party shall be deemed to be recovery for Plan benefits incurred with respect to the injury or sickness for which the third party is liable, regardless of whether or not the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically limited to certain kinds of damages or payments.

The Plan’s right of recovery may be from the third party, any liability or other insurance covering the third party, malpractice insurance; the covered person’s own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP), or any other first or third party insurance coverages which are paid or payable.

If the Plan takes legal action to enforce its recovery rights, the Plan shall be entitled to recover its attorneys’ fees and costs from the covered person.

The covered person shall not do anything to hinder the Plan’s right of recovery. The
covered person shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan’s right of recovery, including assert a claim or lawsuit against the third party or any insurance coverages to which the covered person may be entitled. The Plan is not obligated to pay Plan benefits incurred with respect to a covered person’s injury or sickness until the covered person, or someone legally qualified and authorized to act for the covered person, enters into a written agreement with the Plan regarding its right of recovery. Also, the Plan may suspend payment of Plan benefits if the covered person does not execute such an agreement or does not comply with the terms of such an agreement. Payment of Plan benefits by the Plan before such a written agreement is obtained, or while the covered person is not in compliance with the terms of such a written agreement, shall not constitute a waiver by the Plan of its right of recovery.

The Plan Administrator, in its sole discretion, may waive the Plan’s right of recovery. Waivers may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. The Plan’s waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to another claim; and the Plan’s waiver of its right of recovery with respect to one covered person shall not constitute a waiver of its right of recovery with respect to another covered person.
VIII. PPACA COMPLIANCE

**Pre-Existing Conditions.** Notwithstanding anything contained in this Plan to the contrary, this Plan does not place any limitation or exclusion on coverage of pre-existing conditions for individuals.

**Lifetime/Annual Limits.** Notwithstanding anything contained in the Plan to the contrary, the Plan does not place any lifetime or annual limits on the dollar value of essential benefits for any individual under the group health plan. “Essential benefits” are those defined by the state, in accordance with guidance issued by the Department of Health and Human Services.

**Cost Sharing Requirements for Preventive Care Expenses.** With regard to non-grandfathered benefits under the Plan, there will be no participant cost sharing requirements for any in-network preventive care expenses, as set forth in PPACA and the regulations and guidance issued thereunder.

**Dependent Definition.** The term “Dependent” includes any child of a participant who is covered under an insurance contract, as defined in the contract, or under a self-funded plan, as defined in the plan, to the extent allowed by PPACA and the regulations and guidance issued thereunder.

**No Rescission of Coverage.** The Plan will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

**Selection of Providers.** If a non-grandfathered group health plan or a health insurance issuer offering group or individual health insurance coverage under the Plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider who is available to accept the participant, beneficiary, or enrollee. The plan or issuer must also permit the Participant to designate an in-network pediatrician who is available to accept the participant, beneficiary, or enrollee, and the plan may not require referral or authorization for any in-network obstetrician or gynecologist who is available to accept the participant, beneficiary, or enrollee.

**Emergency Services.** With respect to non-grandfathered benefits under the Plan, a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services.

**Cost Sharing Limits.** With respect to non-grandfathered benefits under the Plan, this Plan does not impose cost sharing amounts (i.e., copayments, coinsurance, and deductibles, but not premiums) that are more than the maximum allowed for high deductible health plans. In 2017, these limits are $7,150 for an individual and $14,300 for family coverage. After 2017, these amounts will be adjusted for health insurance premium inflation. For these purposes, if the Plan utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums
for Essential Health Benefits of a group health plan, the Plan will combine with the annual limitation on out-of-pocket maximums between each provider as an aggregate benefit limit amount.

**Clinical Trials.** With respect to non-grandfathered benefits under the Plan, this Plan will not deny any "qualified individual," as set forth in Public Health Service Act §2709, participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. This Plan also will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. Finally, this Plan will not discriminate against the individual on the basis of the individual's participation in such trial.

**Provider Discrimination.** With respect to non-grandfathered benefits under the Plan, this Plan will not discriminate with respect to participation under the Plan against any health care provider that is acting within the scope of that provider's license or certification under applicable state law, as required by Public Health Service Act §2706(a).

**Applicability.** This section will apply to Welfare Programs under the Plan only if the Welfare Programs are subject to PPACA and if the Welfare Programs do not contain provisions compliant with PPACA.
IX. ERISA RIGHTS

As a participant in this 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:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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) 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) if any, and updated plan document and 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 is required by ERISA to be prepared, in which case, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may 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 this SPD Supplement and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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.

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.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your 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 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 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.
**APPENDIX A**

**SUMMARY OF BENEFIT OPTIONS AND PROVIDER CONTACTS**

<table>
<thead>
<tr>
<th>Welfare Program</th>
<th>Insurance Company or Third Party Administrator</th>
<th>Policy or Contract Number</th>
<th>PPACA Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan (Fully-Insured)</td>
<td>Kalamazoo College 1200 Academy Street Kalamazoo, MI 49006</td>
<td>786919</td>
<td>Applicable</td>
</tr>
<tr>
<td>Priority Health</td>
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<tr>
<td>Effective Date: 01/01/2017</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Kalamazoo College 1200 Academy Street Kalamazoo, MI 49006</td>
<td>G-1013</td>
<td>Applicable</td>
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<tr>
<td>ASR Health Benefits</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date: 01/01/2017</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Group-Term Life for Employees Cigna</td>
<td>Kalamazoo College 1200 Academy Street Kalamazoo, MI 49006</td>
<td>FLX-965171</td>
<td>Applicable</td>
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<td>Effective Date: 01/01/2017</td>
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<tr>
<td>Long-Term Disability (Fully-Insured)</td>
<td>Kalamazoo College 1200 Academy Street Kalamazoo, MI 49006</td>
<td>LK-963589</td>
<td>Applicable</td>
</tr>
<tr>
<td>Cigna</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date: 01/01/2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term Disability (Self-Funded)</td>
<td>Kalamazoo College 1200 Academy Street Kalamazoo, MI 49006</td>
<td>N/A</td>
<td>Applicable</td>
</tr>
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<td>Kalamazoo College</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date: 01/01/2017</td>
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<td></td>
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<tr>
<td>Vision</td>
<td>Kalamazoo College 1200 Academy Street Kalamazoo, MI 49006</td>
<td>1003147</td>
<td>Applicable</td>
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<td>Eye-Med Vision Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date: 01/01/2017</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Employer Requirements for Distributing ERISA Documents

The Plan Administrator/Employer is responsible for preparing the Summary Plan Description ("SPD") and **AFFIRMATIVELY DELIVERING** it to certain persons:

- Covered Employees
- Terminated Cobra Participants
- Parents or guardians of children covered under a qualified medical support order
- Dependents of a deceased participant
- Guardians of an incapacitated person

An employer should be prepared to prove it furnished the SPD in a way "reasonably calculated to ensure actual receipt" using a method "likely to result in full distribution".

I.E., first class mail, hand-delivery, and electronically, if the employees have access to computers in the workplace and can print a copy easily.

Electronic Distribution of ERISA Documents

Employees with work-related computer access

The employee has the ability to access documents at any location where they perform employment duties. Access to Employer’s electronic information system must be an integral part of their normal duties.

- Electronic materials prepared and furnished in accordance with applicable requirements
- Notice is provided to each recipient when furnished, detailing the document
- Notice advises participant of their rights to access the document and how to request a paper copy
- Employer must take steps to ensure the electronic transmittal will result in actual receipt
- If disclosure includes PHI, steps are taken to safeguard the confidentiality of the information

Requirements for Employees with Non-work related computer access or non-employees

May include COBRA participants, dependents or disabled participants.

- Affirmative consent required; Pre-Consent must be obtained, which include details of types of document to be provided, right to withdraw consent, including procedures and updating of information (new email), right to request a paper version and if any cost, and the hardware and software requirements to access the electronic document.
- Pre-Consent statement can be sent electronically if have a reliable e-mail address
- If system hardware or software requirements change, a revised statement must be provided and consent from each individual must be obtained.
- If documents provided on Internet, Consent must be given in a manner that illustrates the individual’s ability to access the information along with a current email address.
- Employer must keep track of individual email addresses for delivery, the consents and actual receipt of emailed documents by recipients.
- These requirements along with the five steps outlined for Employees with work-related computer access above.

ERISA Required Documents for Participants

- SPD - Summary Plan Description
- Restatement of SPD due to Plan Modifications
- SBC - Summary of Benefits and Coverage
- SAR - Summary Annual Report
- Plan Documents
Distribution Instructions

**SPD**
To Participants within 90 days of coverage on existing plan; within 120 days for new plan. Every 5 years if plan amended or every 10 years if no changes made.

**Restatement of SPD**
To Participants no later than 210 days after end of the plan year in which change is adopted.

**SBC**
To participants with enrollment materials, at renewal or reissue of coverage. Special enrollees no later than 90 days from enrollment. Otherwise, within 7 days of written request.

**SAR**
To participants within 9 months after plan year end if Employer is required to file Form 5500 for the benefit plan.

**PLAN DOCUMENT**
Copies must be furnished no later than 30 days after written request.

- **Other Group Health Plan Notices**

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Newborns' and Mothers' Health Protection Act (Newborns' Act), and the Women's Health and Cancer Rights Act (WHCRA)). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided.

Please be sure to check for current laws and regulations on the reporting and disclosure provisions included in the publication on EBSA’s Website at http://dol.gov/ebsa.
Participant Distribution Receipt

The Plan Administrator should provide a copy of the Summary Plan Description to each participant every year.

The Plan Administrator should have each participant sign a copy of this form and should keep the signed copy in the Plan Administrator's records.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Kalamazoo College Wrap Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Start</td>
<td>January 01</td>
</tr>
<tr>
<td>Participant Signature</td>
<td></td>
</tr>
<tr>
<td>Participant Name</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>6-30-17</td>
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