SUMMARY OF MATERIAL MODIFICATIONS

EMPLOYEE BENEFIT PLAN FOR SOUTHWESTERN MICHIGAN COLLEGE

The Employee Benefit Plan has been amended. The changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of the dates specified below.

1. In order to correctly communicate the past, present, and future intent and administration of the Plan, the following provision shall be added to the Plan document effective July 1, 2011. In the event that this provision conflicts or appears to conflict with any existing language pertaining to the payment of claims arising out of automobile accidents, the terms of this amendment will rule:

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS – NON-MICHIGAN RESIDENTS ONLY

Notwithstanding the Payment Priorities rules set forth in the General Provisions section, the following special coordination rule applies regarding automobile insurance. In the event that a Covered Person is injured in an Accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the Covered Person's automobile insurance shall pay as secondary.

2. Effective July 1, 2012, the ***COMPREHENSIVE MEDICAL*** benefit in the **SCHEDULE OF MEDICAL BENEFITS – PREMIER PLAN** section of the Plan document shall be revised to read as follows:

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
COMPREHENSIVE MEDICAL		
Plan Year Deductible per Covered Person	**$500**	**$1,000**
Plan Year Deductible per Family	**$1,000**	**$2,000**
Benefit Percentage Paid (All Covered Expenses, unless specifically stated otherwise)	90% after Deductible until the Maximum Out-of-Pocket is satisfied, then 100% to the end of the Plan Year	60% after Deductible until the Maximum Out-of-Pocket is satisfied, then 100% to the end of the Plan Year

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL, cont.		
Maximum Out-of-Pocket for Comprehensive Medical Covered Expenses per Covered Person per Plan Year	$2,500*	$5,000*
Maximum Out-of-Pocket for Comprehensive Medical Covered Expenses per Family per Plan Year	$5,000*	$10,000*

*Includes Deductible and benefit percentage only. Does not include co-payments of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, are subject to the Pre-Existing Conditions limitation, or are otherwise excluded under the provisions of the Plan. Amounts applied toward the Deductible or Maximum Out-of-Pocket for In-Network services will also accrue toward the Deductible or Maximum Out-of-Pocket for Out-of-Network services, and vice versa. In no event shall the Deductible or Maximum Out-of-Pocket for all In-Network and Out-of-Network services combined exceed the Out-of-Network amounts shown above.

3. Effective July 1, 2012, the ***COMPREHENSIVE MEDICAL*** benefit in the **SCHEDULE OF MEDICAL BENEFITS – STANDARD PLAN** section of the Plan document shall be revised to read as follows:

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL		
Plan Year Deductible per Covered Person	**$1,500**	**$3,000**
Plan Year Deductible per Family	**$3,000**	**$6,000**

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL, cont.		
Benefit Percentage Paid (All Covered Expenses, unless specifically stated otherwise)	80% after Deductible until the Maximum Out-of-Pocket is satisfied, then 100% to the end of the Plan Year	50% after Deductible until the Maximum Out-of-Pocket is satisfied, then 100% to the end of the Plan Year
Maximum Out-of-Pocket for Comprehensive Medical Covered Expenses per Covered Person per Plan Year	$4,000*	$6,000*
Maximum Out-of-Pocket for Comprehensive Medical Covered Expenses per Family per Plan Year	$8,000*	$12,000*

*Includes Deductible and benefit percentage only. Does not include co-payments of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, are subject to the Pre-Existing Conditions limitation, or are otherwise excluded under the provisions of the Plan. Amounts applied toward the Deductible or Maximum Out-of-Pocket for In-Network services will also accrue toward the Deductible or Maximum Out-of-Pocket for Out-of-Network services, and vice versa. In no event shall the Deductible or Maximum Out-of-Pocket for all In-Network and Out-of-Network services combined exceed the Out-of-Network amounts shown above.

4. Effective July 1, 2012, the following change shall be made to the fill limit available through a retail pharmacy as detailed in the **PRESCRIPTION DRUG BENEFIT – *PRESCRIPTION DRUG CARD PROGRAM*** section of the Plan document:

The Plan will allow the Covered Person to fill a prescription for up to and including a **31-day supply**, subject to the Prescription Agreement between the Employer and the Pharmacy Benefits Manager (PBM).

5. Effective January 1, 2013, the ***BENEFIT PERCENTAGE AND DEDUCTIBLE*** subsection in the **COMPREHENSIVE MEDICAL EXPENSE BENEFIT** section of the Plan document shall be revised to read as follows:

BENEFIT PERCENTAGE AND DEDUCTIBLE

Generally, the Plan will pay the percentage stated in the Schedule of Benefits for the amount stated in the Schedule of Benefits, except that the Covered Person or Family, not the Plan, must first pay the amounts necessary to satisfy the Deductibles listed in the Schedule of Benefits. In no event shall the amount payable for covered essential health benefits exceed the Plan Year Maximum Benefit stated in the Schedule of Benefits. Amounts payable for non-essential health benefits will not accrue toward the Plan Year Maximum Benefit. For this purpose, the term "essential health benefits" has the meaning set forth by Health Care Reform (a list of these essential health benefits can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card).

The Deductibles apply to the Covered Expenses of each Plan Year. An individual Deductible need be satisfied only once per Plan Year, regardless of the number of Illnesses, except that once a Family has exceeded the Family Deductible, any remaining Deductibles for individuals within the Family need no longer be met. In no event shall the maximum Deductible for any one Covered Person exceed the amount stated in the Schedule of Benefits; no individual within a Family will be allowed to satisfy "extra" Deductibles in order to fulfill the Family Deductible. **Claims incurred during the last three months of 2011 that were applied toward any Deductible will also be applied toward the satisfaction of Deductibles for 2012. However, this "Deductible carry-over" provision will be discontinued for all future Plan Years. Beginning the last three months of 2012, claims incurred during the last three months of the Plan Year that were applied toward any Deductible will <u>not</u> be applied toward the satisfaction of Deductibles for the next Plan Year.**

All other provisions of the Plan shall remain in effect and unchanged.

NOTE: If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact ASR Health Benefits at (800) 968-2449.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact ASR Health Benefits at (800) 968-2449.