

SUMMARY PLAN DESCRIPTION

MEDICAL, DENTAL and VISION PLANS

June 1ST, 2009 THROUGH May 31ST, 2010

Name of Plan:

Jackson Community College

Policy Number:

68238-000 Medical - Faculty Option 1

68238-003 Medical - Faculty Option 2

68238-004 Medical - Admin & Admin Assistants

68238-006 Medical - Support Staff

68238-Dental

68238-Vision

MEBS-HRA Deductible Wrap

Participants Included:

Full time employees working minimum of 30 hours per week.

Name and Address of Employer:

Jackson Community College
2111 Emmons Rd.
Jackson, MI 49201

Employer IRS Identification #: 38-1795703

Employee Contributions:

Per schedule

Plan Identification Numbers:

1. #501 (Medical Plan)
2. #502 (Dental Plan)
3. #503 (Vision Plan)
4. #594 (HRA deductible WRAP)

Plan Year Ends:

May 31st

Plan Administrator, Name, Address, and Telephone #:

Jackson Community College
2111 Emmons Rd.
Jackson, MI 49201
517-796-8403

Agent for Service of Legal Process on the Plan:

Jackson Community College
2111 Emmons Rd.
Jackson, MI 49201
517-796-8403

Type of Administration

Insured policies

Benefits:

Medical, Dental and Vision

(Plans are subject to deductibles, co-pays, and maximum benefit amounts)
See Summaries of benefits for those plans elected.

See www.bcbsm.com for network providers and other pertinent information.

The employer may modify, amend, or terminate the plan at any time at its sole discretion. Any modification, amendment, or termination will be communicated to participants under the plan.

The insurance company has the right to modify, amend, or terminate the plan as follows:

Change RX Formulary
Change Network Providers

Insurance Companies:

Blue Cross Blue Shield of Michigan
Phone: 800-788-7334 (customer service, claims, appeal etc.,)

MEBS
Phone: 800-968-9682 (customer service, claims, appeal etc.,)

Insurance Agency:

Walton Agency
Phone: 800-837-2601

COBRA Administrator:

Corporate Benefit Strategies, Inc.,

WHAT ARE YOUR RIGHTS UNDER ERISA?

As a participant in the group insurance 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) 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) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age * * *) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

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 summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, 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, which 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.

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 issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).