EMPLOYEE NOTIFICATION NUMBER 8
TO
PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
KNOX COLLEGE

BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the “Plan”) is hereby amended to reflect the following, effective July 1, 2009:

Under COVERED MEDICAL EXPENSES, the following benefit has been added:

Charges for the diagnosis and treatment of Autism Spectrum Disorder for children under age twenty-one (21). Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger’s disorder, and pervasive developmental disorder not otherwise specified.

Diagnosis means one or more tests, evaluations or assessments to diagnose whether an individual has Autism Spectrum Disorder that is prescribed, performed or ordered by a physician licensed to practice medicine in all its branches or a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorder.

Treatment shall include the following care when prescribed, provided or ordered by a physician or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorder when the care is determined to be Medically Necessary.

Psychiatric care;

Psychological care;

Habilitative or rehabilitative care including professional, counseling and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain and restore the functioning of an individual. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior; and

Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

Self-care and feeding;
Pragmatic, receptive and expressive language;
Cognitive functioning;
Applied behavioral analysis, intervention and modification;
Motor planning; and
Sensory processing.

Upon request a provider of treatment for Autism Spectrum Disorders shall furnish medical records, clinical notes or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the Plan may request a treatment plan
consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the
anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

When making a determination of medical necessity for a treatment modality for Autism Spectrum
Disorders, the Plan must make the determination in a manner that is consistent with the manner used
to make that determination for other diseases or illnesses. Any challenge to medical necessity must be
reviewed by a physician with expertise in the most current and effective treatment modalities for
Autism Spectrum Disorders.

Coverage for Medically Necessary early intervention services must be provided by certified early
intervention specialists.

Coverage is limited to a maximum benefit of $36,000 per person per Calendar Year.

Under SCHEDULE OF BENEFITS, in the SPECIAL COVERAGES section, the following benefit has
been added:

<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
<th>OUT-OF-AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges for the diagnosis and treatment of Autism Spectrum Disorder</td>
<td>Benefits are based on place/type of service</td>
<td>Benefits are based on place/type of service</td>
<td>Benefits are based on place/type of service</td>
</tr>
</tbody>
</table>

Calendar Year Maximum - $36,000 per person

Under COVERED MEDICAL EXPENSES, the following benefits have been added:

Charges for a shingles vaccine age sixty (60) and older.

Charges for a human papillomavirus vaccine (HPV).

Under COVERED MEDICAL EXPENSES, the following benefit has been added:

Medically Necessary pain medication and pain therapy related to the treatment of breast cancer.

Routine mammograms according to the following schedule, including digital mammography:

- A baseline mammogram for women age 35-39 years of age
- An annual mammogram for women age 40 and older
- A mammogram at the age and intervals considered Medically Necessary by the woman’s
  health care provider for women under age 40 and having a family history of breast cancer,
  prior personal history of breast cancer or other risk factors.

A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates
heterogeneous or dense breast tissue when Medically Necessary as determined by a physician.

Routine mammograms and the ultrasound are covered at 100% when using a network provider, not
subject to a co-pay or deductible and not subject to any annual or lifetime maximum benefit.

If a non network provider is used, charges will be covered at the same benefit level as other non
network services.
Under **SCHEDULE OF BENEFITS**, in the **SPECIAL COVERAGE**s section, the following benefit has been added:

<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
<th>OUT-OF-AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram</td>
<td>100% No Deductible</td>
<td>70% Benefit, Deductible Applies</td>
<td>80% Benefit, Deductible Applies</td>
</tr>
</tbody>
</table>

Under **ELIGIBLE DEPENDENTS**, the following has been added:

**Extended Dependent Age Coverage**

Additional categories for dependent coverage have been added to the Plan due to the enactment of Illinois Public Act 95-0958.

Unmarried dependent Children under the age of twenty-six (26) who are not enrolled as a full-time student are eligible, residency requirements with the Employee or in Illinois are not required.

Unmarried military veteran dependent Children under the age of thirty (30) who are not enrolled as a full-time student are eligible, residency requirement with the Employee is not required but the dependent must be a resident of Illinois.

In addition military veteran dependent Children must have:

- Served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
- Received a release or discharge other than a dishonorable discharge; and
- Submitted proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a “Certificate of Release or Discharge from Active Duty”.

There will be an initial one time ninety (90) day Enrollment Period beginning on the first day of the renewal month during which a dependent may enroll, this Plan’s renewal month is July. The effective date for dependents added within the ninety (90) day Enrollment Period will be consistent with the enrollment terms of the Plan. During the initial ninety (90) day enrollment period, requirements for creditable coverage, continuous coverage or breaks in coverage will not be applied.

After the initial Enrollment Period Plans will allow enrollment for these eligible dependents during the Plan’s annual enrollment period. For Plans that do not have an annual enrollment period, enrollment will be allowed during the thirty (30) day period immediately prior to the Plan’s renewal date. To be added during this time, eligible dependents may need to meet a requirement of ninety (90) days of continuous coverage without a break in coverage of more than 63 days.
Under **WHEN DEPENDENTS CEASE TO BE ELIGIBLE**, the following has been added:

In accordance with Michelle’s Law when a student ceases to meet the criteria for full-time student status due to a Medically Necessary leave of absence, coverage will continue until the earlier of one year after the first day of the Medically Necessary leave of absence, or the date on which the coverage would have otherwise ended. The child must be enrolled as a dependent under the health plan and qualify for coverage on the basis of being a student at a postsecondary educational institution, immediately before the Medically Necessary leave of absence involved. Written certification must be provided by a treating physician of the dependent child certifying that such individual is suffering from a serious illness or injury that would require a Medically Necessary leave of absence.

**INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET**
EMPLOYEE NOTIFICATION NUMBER 7
TO
PLAN DOCUMENT AND
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FOR
KNOX COLLEGE

BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the "Plan") is hereby clarified to reflect the following, effective June 1, 2009:

Under PLAN PARTICIPATION, in the ELIGIBLE EMPLOYEES section, the Participation paragraph has been deleted and replaced with the following:

All employees who work at least eight hundred sixty-six (866) hours per year.

EMPLOYEES ELIGIBLE FOR POST RETIREMENT BENEFITS

Participation - You are eligible for Participation if you are age forty-five (45) and you were hired by the College in a benefits eligible position prior to January 1, 1992.

Benefits - You will be eligible to retire and receive Post Retirement Benefits when you reach age fifty-five (55) provided you have ten (10) years of Participation Service.

Participation Service is defined as service with the College after age forty-five (45).

Note: Employees hired on or after January 1, 1992, will not be eligible for Post Retirement Benefits.

Under PLAN PARTICIPATION, in the ELIGIBLE DEPENDENTS section, paragraph three (3) has been deleted and replaced with the following:

For purposes of this benefit, "Retiree" is defined as an Employee who was hired prior to January 1, 1992, in a benefits eligible position, has attained age fifty-five (55) and has at least ten (10) years of service.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET
EMPLOYEE NOTIFICATION
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In accordance with the new provisions of the Family Medical Leave Act (FMLA) and the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), your Plan has been revised to include the following language:

EFFECTIVE JANUARY 16, 2009

Under PLAN PARTICIPATION, the FAMILY MEDICAL LEAVE ACT (FMLA) section has been deleted and replaced with the following:

If a Covered Employee ceases active service due to a Company approved Family Medical Leave of absence in accordance with the requirements of Public Law 103-3 (or in accordance with any state or local law which provides a more generous medical or family leave and requires continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had the Covered Employee continued active service.

If the Covered Employee does not return to active service after the approved Family Medical Leave or if the Covered Employee has given the employer notice of intent not to return to active service during the leave, or if the Covered Employee has exhausted the FMLA leave entitlement period, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided the Covered Employee elects to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. the Covered Employee or Covered Dependent was covered under this Plan on the day before the FMLA leave began or becomes covered during the FMLA leave; and

2. the Covered Employee does not return to active service after an approved FMLA leave; and

3. without COBRA, the Covered Employee or Covered Dependent would lose coverage under this Plan.

However, these conditions do not entitle a Covered Employee to COBRA if the Company eliminates, on or before the last day of the Covered Employee’s FMLA leave, coverage under this Plan for the class of Employees (while continuing to employ that class of Employees) to which the Covered Employee would have belonged if the Covered Employee had not taken FMLA leave.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. the date a Covered Employee fails to return to active service after an approved family medical leave;

2. the date the Covered Employee informs the Company of intent not to return to active service; or

3. the date a Covered Employee exhausts the FMLA leave entitlement period and does not return to active service.
The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period.

If a Covered Employee declines coverage during the FMLA leave period or if the Covered Employee elects to continue coverage during the family or medical leave and fails to pay the required contributions, the Covered Employee is still eligible under the Continuation of Coverage (COBRA) provision at the end of the FMLA leave. COBRA continuation will become effective on the last day of the FMLA leave.

The pre-existing conditions limitation will not apply if a Covered Employee does not experience a break in coverage of sixty-three (63) days or more (defined as a "significant break in coverage"). The Covered Employee will be totally responsible for the contributions during the COBRA continuation if elected; however, the covered employee is not required to pay any unpaid contributions for the time coverage had lapsed during the leave.

If a Covered Employee voluntarily terminates coverage under this Plan during the FMLA leave or if coverage under this Plan was terminated during an approved family medical leave due to non-payment of required contributions by the employee and the employee returns to active service immediately upon completion of that leave, coverage will be reinstated as if the employee remained in active service during the leave, including dependent coverage, without having to satisfy any waiting period, pre-existing conditions, limitations or evidence of good health provisions of this Plan, provided the employee makes any necessary contribution and enrolls for coverage within thirty-one (31) days of the return to active service.

EFFECTIVE APRIL 1, 2009

Under PLAN PARTICIPATION, in the SPECIAL ENROLLMENT PERIODS section, the following has been added:

An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enter the Plan during a "Special Enrollment Period" when the following conditions are met:

You or a Dependent are covered under Medicaid or any state’s Child Health Insurance Program (CHIP) and the coverage is terminated as a result of the loss of eligibility under either Medicaid or CHIP, or

You or a Dependent becomes eligible for a premium assistance subsidy for group health coverage under Medicaid or CHIP.

Enrollment under these conditions must be requested within sixty (60) days after the date of termination of coverage under Medicaid or CHIP or the date of eligibility determination for a premium assistance subsidy under Medicaid or CHIP.

Effective Date

Coverage will become effective not later than the first day of the first month beginning after the date the completed request for enrollment is received.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET
EMPLOYEE NOTIFICATION NUMBER 6
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BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the “Plan”) is hereby amended to reflect the following, effective April 1, 2008:

Under MEdICAL SCHEDULE OF BENEFITS, in the SPECIAL COVERAGES section, the following benefit has been added:

<table>
<thead>
<tr>
<th>SUMMARY OF SERVICES</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Worksite Health Screening through Interactive Health Solutions (IHS) (employees and spouses)</td>
<td></td>
<td>100% No Deductible</td>
<td></td>
</tr>
</tbody>
</table>

The WORKSITE HEALTH SCREENINGS section has been added:

This program is a voluntary part of the Company’s health benefit and is administrated through Interactive Health Solutions (IHS). The worksite health screening is free and helps you and our Company control health care costs and improve Employee productivity by helping you get healthy and stay healthy.

The health screening consists of a simple blood draw and features a battery of 34 diagnostic tests to detect a wide range of health problems including cardiovascular disease risks (high cholesterol, high blood pressure, and diabetes), liver and kidney disease, anemia, and certain types of cancer. They also analyze self-reported health information to assess risks for heart attacks, strokes, mental health problems, and sleep disorders. The result is a complete evaluation of your health state.

After your health screening, IHS will notify you by email (if you provide an email address) when you can access your test results on their website www.interactivehs.com. You will also receive a completely confidential Personal Health Report in the mail. The PHR is an easy to understand health profile that outlines health screening results, reviews potential health problems (health risks), and describes personalized strategies for the individual to address health problems and stay healthy in the long term.

In the near future you will receive information with the dates and locations the screenings will take place. The results are confidential and your employer will not receive any of your personal health information.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET
EMPLOYEE NOTIFICATION NUMBER 5
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BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the "Plan") is hereby amended to reflect the following, effective August 1, 2008:

Under OTHER HEALTH BENEFIT PLAN INFORMATION, in the COORDINATION OF BENEFITS section, the Coordination Procedure has been deleted and replaced with the following:

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total Allowable Expenses incurred during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits either as an insured person or employee or as a dependent under any other plan which has no provision similar in effect to this provision; or

2. Dependents’ benefits under this Plan for a dependent who is also eligible for benefits as an insured person or employee under any other plan or as a dependent covered under another group plan; or

3. Benefits under this Plan for an Employee who is also eligible for benefits as an insured person or employee under any other plan, and has been covered continuously for a longer period of time under such other plan; or

4. If an eligible dependent elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to co-insurance and/or deductibles not covered under the HMO and eligible expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the dependent chose not to avail himself/herself to the HMO participating provider.

5. If a Medicare eligible Retiree (and his covered Dependents) is covered under this Plan, benefits under this Plan are limited to co-insurance and/or deductibles not covered by Medicare and eligible expenses that are specifically excluded by Medicare but covered under this Plan.

For Services rendered to a Medicare eligible Retiree and/or his Dependents by a provider that is not a participating Medicare provider (does not accept Medicare assignment), the Knox College Group Health Plan shall only pay benefits as a secondary plan and such benefits shall be limited to twenty percent (20%) of eligible covered expenses. This provision will not apply when an employee is out of the country and Medicare provider is not available.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET
EMPLOYEE NOTIFICATION NUMBER 6

TO

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KNOX COLLEGE

BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the “Plan”) is hereby amended to reflect the following, effective May 1, 2008:

Under MEDICAL EXPENSE BENEFIT, in the COVERED MEDICAL EXPENSES section, number forty-two (42) has been added:

42. FDA approved medications used for conditions other than those for which they received FDA approval, when considered the standard of care and not part of a clinical study or in conjunction with any experimental treatment. For the purposes of this Plan, Standard of Care is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, or the National Institute of Health, and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness.

Under MEDICAL EXPENSE BENEFIT, in the MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS section, number two (2) has been deleted and replaced with the following:

2. Charges for experimental drugs that:

a. Are not commercially available for purchase;

b. Are not approved by the Food and Drug Administration (FDA) for general use;

c. Are not being used for the condition or illness for which they received FDA approval, except as shown as a covered expense.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET
EMPLOYEE NOTIFICATION NUMBER 3
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BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the “Plan”) is hereby amended to reflect the following, effective March 1, 2008:

Under OTHER HEALTH BENEFIT PLAN INFORMATION, in the COORDINATION OF BENEFITS section, the Secondary Amount Rule has been deleted and replaced with the following:

If the Employee’s spouse is employed and is covered under any type of group health plan or medical plan (i.e HRA, MRP, etc.) sponsored by his/her employer that has different benefit levels than plans for Employees who do not have secondary coverage, the Knox College Group Health Plan shall only pay benefits as a secondary plan and such benefits shall be limited to twenty percent (20%) of covered expenses.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET
EMPLOYEE NOTIFICATION NUMBER 2
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BY THIS AGREEMENT, Knox College Group Medical Benefit Plan (hereinafter referred to as the “Plan”) is hereby amended to reflect the following, effective July 1, 2007:

The **DISEASE MANAGEMENT** section has been added:

Disease Management is a voluntary program that is designed to improve the lives of individuals suffering from chronic, yet treatable, diseases through education, lifestyle choices, self-care and healthcare intervention.

Chronic illness, such as heart disease, asthma and diabetes, are among the most prevalent, costly and treatable of all health problems. This free benefit program provides you with the opportunity to receive the tools and information you need to manage your healthcare and the related healthcare costs. The Disease Management program is staffed by medical professionals who will consult with you and your physician when a chronic medical condition is identified.

The goal of the Disease Management program is to intervene prior to a catastrophic medical event and to assist you in navigating through the healthcare system if a serious medical event does occur. To accomplish this goal, the Disease Management program provides the highest level of service at the earliest opportunity through education, intensive healthcare management and cost effective care for your specific condition.

The Disease Management program complies with HIPAA’s privacy regulations; your health information will be kept confidential and will only be shared with the people you choose.

**The Process**

Care Managers identify individuals with chronic medical conditions.

You will receive a telephone call from a Care Manager. If you cannot be reached by telephone, the Care Manager will send information regarding the Disease Management program to you in the mail.

You will complete a Health Risk Assessment (HRA) during a telephone interview with the Care Manager.

Following the Health Risk Assessment (HRA) process, the Care Manager uses disease-specific protocols and guidelines to educate you and manage your case. These guidelines outline the specific needs of your condition and the expected outcomes.

**The Key Features and Benefits**

You will receive a packet explaining the Disease Management program and educational information that is specific to your medical condition.

Care Managers will provide intensive planning and case management for medical situations by recommending alternate treatment plans, arranging home health care services and equipment rental and coordinating the services of the many providers that may be involved in these designated situations.

The Disease Management program does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

**INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET**