Illinois Wesleyan University
Retiree Health Benefits Program

Summary Plan Description

This Summary Plan Description ("SPD") provides an overview of the Illinois Wesleyan University Retiree Health Benefits Program (the "Program"). This SPD supplements the information provided in the benefits booklet or summary plan description describing each of the Program's component parts. This SPD describes the Program in effect as of January 1, 2011, except as otherwise specifically indicated.

Program Overview

The Retiree Health Benefits Program consists of two plans funded by Illinois Wesleyan University (the "University"):

1. Defined Benefit Plan; and

2. Defined Contribution Plan.

Participation in the Defined Benefit Plan was frozen effective August 1, 2011. Accordingly, no employee who retires after July 31, 2011 is eligible to participate in the Defined Benefit Plan. To be eligible to participate in Defined Contribution Plan, an eligible employee must be at least 55 years of age and have at least ten years of continuous service at the time of his or her retirement from the University.

Defined Benefit Plan

The Defined Benefit Plan, sometimes referred to as the DB$500 Plan, provides traditional health insurance coverage (medical, prescription drug and dental). The University contributes $500 per month toward the cost of coverage for each eligible retiree participating in the Defined Benefit Plan who is age 55 or older. The retiree is responsible for paying the balance of the monthly premium for him- or herself and the entire premium for the coverage of the retiree's spouse or domestic partner and any eligible dependent children. The retiree also is responsible for the payment of all copays, deductibles and co-insurance amounts.

The Defined Benefit Plan is coordinated with Medicare and provides supplemental coverage for those who are eligible for Medicare (i.e., generally those age 65 or older). Retirees and any covered dependents are responsible for enrolling in Medicare Parts A and B when first eligible and for paying to Medicare the applicable monthly premium.

The Defined Benefit Plan currently provides medical insurance coverage, including prescription drug benefits, through the same two options available to active employees, one administered by Humana/OSF Health Plans and the other by Health Alliance Medical Plans. A third medical and prescription drug benefits option, administered by Benistar, provides coverage only for Medicare-eligible participants. The dental insurance coverage provided is administered by

Principal Financial Group. Changes between coverage options may be made as part of the annual open enrollment process.

Enrollment in the Defined Benefit Plan was limited to regular full-time employees who were age 55 or older and had at least ten years of continuous service as of both the employee's retirement date and July 31, 2010, who retired no later than July 31, 2011, and who submitted a written retirement election to Human Resources no later than July 31, 2010.

Any retiree who elected to participate in the Defined Benefit Plan was not eligible to participate in the Defined Contribution Plan.

Defined Contribution Plan

The Defined Contribution Plan consists of individual accounts – one funded and one notional – that are credited with annual employer contributions plus accumulated interest and investment earnings. In addition, eligible retirees have access to several insurance coverage options. During retirement, a retiree may use the funds in his accounts to pay for health insurance premiums and for qualified medical expenses not covered by insurance.

Effective August 1, 2009, two accounts were established under the Defined Contribution Plan for each regular full-time employee age 45 or older. A "regular full-time employee" for purposes of the Retiree Medical Program is an employee who is regularly scheduled to work at least 30 hours per week at least nine months each year and who is not classified as an adjunct faculty member or as a temporary or part-time employee. A regular full-time employee who was not 45 as of August 1, 2009 will have accounts established for him or her the month the employee turns age 45 (or, if later, the date the employee becomes a regular full-time employee due to his or her hire or change in employment status at or after age 45).

One account is funded and one account is notional (unfunded). The University will credit a total of $1500 per year to these two accounts for up to 20 years of continuous service earned after the age of 45. For the 2009–2010 fiscal year, $300 was credited to each eligible employee's funded account and $1200 was credited to each employee's notional account. In addition, eligible employees received notional account credit for service earned prior to August 1, 2009, for each year of continuous service after reaching age 45 (subject to the 20 years of continuous service maximum).

Special Rules for Eligible Employees Hired Between August 1, 2007, and July 31, 2009. If an individual was hired as a regular full-time employee between August 1, 2007, and July 31, 2009, the University contributed $1500 per year during this period to a funded account established for him or her under the Defined Contribution Plan. Contributions made to an employee account during this period are considered in applying the 20 years of contributions maximum described above.

The funded account is part of the University's Emeriti Retiree Health Plan, is invested in the investment option(s) selected by the employee and is credited with investment earnings and losses. The notional account is maintained in the University's Notional Account Health Reimbursement Arrangement Plan administered by Benefit Planning Consultants and is credited with interest annually. The current interest crediting rate for notional accounts is 6.25 percent

compounded annually. Investment earnings and interest credited are not subject to income taxes under current law.

During retirement, a retiree may use the funds in his or her accounts to pay qualifying medical expenses, including premiums for health insurance coverage. Distributions for this purpose currently are not subject to income taxes.

The health insurance coverage options available for Defined Contribution Plan participants and their eligible dependents vary depending upon whether an individual is eligible for Medicare. Prior to becoming eligible for Medicare, a participant, upon his or her retirement at or after age 55 with at least ten years of continuous service, may elect to continue participating in the active employee medical and dental options in which he or she is then enrolled. Changes between available coverage options may be made as part of the annual open enrollment process.

Once a retiree becomes eligible for Medicare, one or more insurance options providing Medicare supplemental coverage are available to those age 65 or older through the Emeriti Plan. And many insurers offer similar coverage through Medicare supplemental policies.

Defined Contribution Plan participants may use the funds in their accounts to pay the premiums for any of these insurance coverage options as well as for other qualifying medical expenses such as copays and deductibles.

An eligible employee may retire from his or her employment with the University and receive benefits under the Defined Contribution Plan if he or she is age 55 or older and has at least ten years of continuous service as of the employee's retirement date. Employer contributions to an employee's accounts and interest and earnings thereon are forfeited if an employee's employment with the University ends before the employee has completed at least ten years of continuous service and attained age 55.

A retiree may not elect to retire under both the Defined Contribution Plan and the Defined Benefit Plan. If an employee, upon retirement, enrolled in the Defined Benefit Plan, the amounts credited to the employee's funded and notional accounts under the Defined Contribution Plan were forfeited and are not be available for use by the retiree.

Employee After-Tax Contributions Account

Employees who participate in the Defined Contribution Plan are eligible to make after-tax contributions by payroll deduction to an account established for them in the Emeriti Retiree Health Plan. The account is invested in the investment option(s) selected by the employee, and is credited with investment earnings and losses. Investment earnings are exempt from income taxes.

Funds in an after-tax contributions account may be used to pay qualifying medical expenses, including premiums for health insurance coverage, once the employee has attained age 55 and his or her employment with the University ends. Distributions for this purpose are not subject to income taxes.

Employee after-tax contributions are always fully vested. This means that the balance of the account will not be forfeited even if the employee's employment with the University ends before the employee has completed at least ten years of continuous service and attained age 55. However, access to the account generally is not permitted until age 55. The balance of the after-tax contributions account also was not forfeited if the employee elected to enroll in the Defined Benefit Plan upon retirement.

Eligibility

Participation in the Defined Benefit Plan was frozen effective August 1, 2011. Accordingly, no employee who retires after July 31, 2011 is eligible to become a participant in the plan.

A regular full-time employee is eligible to retire from his or her employment with the University and to receive benefits under the Defined Contribution Plan is he or she meets all of the following criteria at the time of retirement from the University:

- Regular full-time employee age 55 or older with at least ten years of continuous service; and

- Did not elect to participate in the Defined Benefit Plan or is not eligible to do so.

A "year of continuous service" is defined as each 12-month period of employment with the University as a regular full-time employee from an employee's most recent date of hire until his or her employment ends. An employee is considered a "regular full-time employee" if he or she is regularly scheduled to work at least 30 hours per week for a minimum of nine months per year.

Adjunct faculty, temporary and part-time employees are not eligible to participate in the Program, and time worked in those classifications is not counted as continuous service for Program purposes.

Enrollment at Retirement

To enroll in the Defined Benefit Plan, an eligible employee must have submitted a written retirement election to Human Resources on or before July 31, 2010, and must have retired from his or her employment with the University no later than July 31, 2011. If an eligible employee did not enroll in the Defined Benefit Plan in this manner, he or she may not enroll later.

Retirees who meet the requirements for participation in the Defined Contribution Plan will be automatically enrolled with respect to their funded and notional accounts provided they did not enroll in the Defined Benefit Plan at the time of retirement or are not eligible to do so. Defined Contribution Plan participants who want to enroll in one of the insurance coverage options must enroll in one of those options within 30 days of their retirement date (or within 90 days in the case of any Emeriti Health Insurance Plan options).

Retirees wishing to enroll their eligible dependents in an insurance coverage option may do so at the same time the retiree enrolls or during any subsequent annual open enrollment period, unless the applicable coverage option specifically provides otherwise.

Benefits

For information about the benefits offered under each of the component parts of the Program, please refer to the respective benefits booklet or summary plan description.

Retiree Premiums

The required retiree contribution for any insurance coverage option is payable monthly and is due the first day of the month unless the particular coverage option specifically provides otherwise. Coverage may be terminated if a required monthly premium is not paid within 30 days of its due date. If insurance coverage is terminated for nonpayment, the retiree and/or dependent whose coverage is lost due to nonpayment may not later enroll in any insurance coverage option maintained or sponsored by the University.

When Coverage May End

The University currently intends to continue providing health benefits to eligible retirees and their eligible dependents. However, circumstances could change and, as a result, the University might decide to significantly change the terms of the Program or one or more of the plans or parts thereof. The University also reserves the right to terminate the Program altogether.

A retiree's coverage under the Program will terminate as of the date when he or she is no longer a participant in any of the Program's component parts.

Program Administration

The Program is administered by the University's Retiree Health Insurance Committee ("Administrator"). The Administrator's address is Retiree Health Insurance Committee, Attention: Vice President for Business and Finance, Illinois Wesleyan University, 1312 N. Park Street, Bloomington, Illinois 61701, and its phone number is 309-556-3971.

The Administrator shall have the discretionary authority to carry out all actions necessary for the administration of the Program and to promulgate rules, procedures and practices for the Program's administration. The Administrator shall have the power and discretion to construe any disputed or ambiguous terms, determine all questions relating to the administration of the Program, including eligibility and the amounts payable, and the authority to review and resolve all claims for benefits. All decisions by the Administrator shall be final and binding on all employees and their beneficiaries. The Administrator shall have the authority to delegate to others responsibility for performing administrative functions.

In the event a benefit is paid in error, the Administrator and University shall have the right to recover any such amount.

Claims Procedure

This claims procedure governs Program eligibility determinations and other matters not covered under the claims procedure of any particular component part of the Program. For example, if a claim for benefits of a retiree enrolled in the Health Alliance Medical Plan is denied because the

treatment is not covered under the terms of the Health Alliance Medical Plan, the claims procedures described in the benefits booklet or summary plan description for the Health Alliance Medical Plan will govern. In contrast, if an employee believes that his or her years of continuous service for eligibility purposes have not been correctly determined, the claims procedure described here will govern.

If an employee or retiree, or a spouse, domestic partner or dependent child thereof, believes he or she is entitled to participate in or to receive a benefit under the Program, the claimant should file a claim by sending the claim, in writing, to the Administrator in accordance with this section. Within 30 days after receipt of a claim, the Administrator or its designee will notify the claimant in writing of the determination. If the claim is denied, the written notice will tell the claimant the reason for the denial and what additional information, if any, is needed, which could change the decision to deny the claim. The notice will also tell the claimant how he or she can go about having the decision reviewed. In some cases the Administrator might need more time. If this happens, the claimant will be notified that an additional period of time (not exceeding 30 days) is required.

If the claim is denied, the claimant may appeal the denial and have the claim reviewed by the Administrator. The appeal should be sent in writing to the Administrator and should explain the reason(s) why the claimant believes the claim should have been allowed. Any facts and supporting documentation not previously submitted to the Administrator should be included with the Appeal. A claimant has 180 days to file an appeal from the time he or she is notified of the denial.

The Administrator will normally respond within 60 days after receiving an appeal. In special cases, the Administrator may advise the claimant that an additional 60 days will be required to review the appeal. The decision will be in writing and will include specific reasons for the Administrator's decision and references to provisions of the Program and any rules, procedures or practices on which it is based. The decisions of the Administrator shall be final and binding on all employees, retirees and their beneficiaries.

A claimant may not pursue any legal action for benefits unless he or she has exhausted the claims appeal procedure. The Program's agent for service of legal process is the Vice President for Business and Finance, Illinois Wesleyan University, 1312 North Park Street, Bloomington, Illinois 61701.

ERISA Rights

As a participant in the Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA"). ERISA provides that all Program participants shall be entitled to:

Receive Information About Your Program and Benefits

Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Program, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed

by the plan with the Employee Benefits Security Administration and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Administrator, copies of all documents governing the operation of the Program, 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 Program's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health coverage for yourself, your spouse or your 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 the summary plan descriptions and the documents governing the Program's component parts 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 under 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 the 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 from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Program review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 the plan fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the Employee Benefits Security Administration, 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 the Program, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

Additional Information

Please refer to the applicable summary plan description or benefits booklet for contact information for the various entities involved in providing claims administrative services and insurance under the Program.

The sponsor of the Program is Illinois Wesleyan University, 1312 N. Park Street, Bloomington, Illinois 61701. The sponsor's federal employer tax identification number is 37-0662594. Service of legal process may be served on the Program sponsor or the Plan Administrator.

The Program is funded through University and participant contributions. Certain benefits are insured. For insurer information, please refer to the applicable benefits booklet or summary plan description.

For questions about the Program, you may contact the applicable claims administrator or insurer, or Human Resources at 309-556-3536.