FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway • Kansas City, Missouri 64111-2406 • (800) 648-8624

Group Insurance Certificate Providing Limited Benefits for Vision Care Non-Participating

This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

GENERAL INFORMATION

About Your Insurance - This Certificate explains the plan of insurance which is underwritten by Fidelity Security Life Insurance Company. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing Your Group Number and Your Effective Date.

Important Notice - Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

DEFINITIONS

The following terms have specific meaning as used in the Policy.

Covered Person means an employee meeting the eligibility requirements of the Policy who is covered for benefits. Covered Person will also include Your Dependents, if enrolled.

Dependent means any of the following persons: 1) Your lawful spouse; 2) Each unmarried child from birth to age 19 who is primarily dependent upon You for support and maintenance; 3) Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) Each unmarried child at least 19 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday. Child includes stepchild, foster child, legally adopted child, child legally placed in Your home for adoption, and child under Your legal guardianship. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 20 or more hours weekly for six or more months.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder on the face of the Policy.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing Optician.

Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Vision Materials means corrective lenses and/or frames or contact lenses.

We, Our, Us means Fidelity Security Life Insurance Company.

You, Your, Yours means the employee covered under the Policy.

DEFINITIONS (PPO and Non-PPO)

Preferred Agreement means an agreement between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

Non-Preferred Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Agreement with the PPO.

Preferred Provider means a Provider who has signed a Preferred Agreement with the PPO.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area who have signed Preferred Agreements with the Company.

PPO Service Area means the geographical area where the PPO is located.

EFFECTIVE DATES

Effective Date of Employee's Insurance - Your insurance will be effective as follows: 1) If the Policyholder does not require You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible; 2) If the Policyholder requires You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible, provided; a) You have given Us Your enrollment form (if required) on, prior to, or within 30 days of the date You became eligible; and b) You have agreed, in writing, to pay the required contributions; 3) If You fail to meet the requirements (a) and (b) within 30 days after becoming eligible, Your coverage will not become effective until We have verified that You have met these requirements. You will then be advised of Your effective date.

Effective Date of Dependent's Insurance - Coverage for Dependents becomes effective on the later of: 1) the date Dependent Coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

Newborn Children - If a Dependent is covered under Your Certificate, a Dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. In order to continue coverage beyond this 31-day period, You must send Us notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period.

Adopted Children - If a Dependent child is placed with You for adoption while the Certificate is in force, such child will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send in notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

Benefit	Preferred Provider	Non-Preferred Provider	Benefit Period
Vision Materials:	$15.00 copayment	N/A	
Standard Lenses			12 months
Single	Paid in full after copayment	$25.00	
Bifocal	Paid in full after copayment	$40.00	
Trifocal	Paid in full after copayment	$50.00	
Lenticular	Paid in full after copayment	$80.00	
Progressive	$50.00	$40.00	
Frames	$50.00	$45.00	24 months
*Contact Lenses**			12 months
Elective	$130.00	$130.00	
Medically Necessary	Paid in full	$250.00	

**Contact Lenses* includes fit, follow-up and Materials.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company, shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions.

Benefit Period for Vision Materials is shown in the Schedule of Benefits and begins on the Covered Person's Effective Date.

Vision Materials Benefit - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - Up to two lenses provided one time in each successive Benefit Period.
- Frame - One frame provided one time in each successive Benefit Period.
- Contact Lenses - Contact lenses benefit provided in lieu of lenses and/or frame.

LIMITATION

Vision Materials Only - Fees charged by a Provider for services other than covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes, or supporting structures; 3) Any Vision Examination; 4) Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 5) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof; 6) Plano (non-prescription) lenses; 7) Non-prescription sunglasses; 8) Two pair of glasses in lieu of bifocals; or 9) Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

TERMINATION OF INSURANCE

For all Covered Persons - All Covered Persons' insurance will end automatically on the earliest of the following dates: a) The date the Policy ends; b) The end of the last period for which any required contribution agreed to in writing has been made; c) The date You are no longer eligible for insurance; d) The date Your employment with the Employer ends. Your coverage will end on the last day of the month in which employment ends. The Employer may, at its option, continue Insurance for individuals whose employment has ended, if it: (i) does so without individual selection between employees; and (ii) if it continues making premium payments for those individuals.

For Dependents - A Dependent's insurance will automatically stop on the earlier of: a) the date Your coverage ends; b) the end of the month in which the Dependent ceases to be Your Dependent; c) the end of the last period for which any required contribution has been made.

A Dependent Child will not cease to be a Dependent solely because of age if the child is: a) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and b) mainly dependent on You for support.

We may ask for proof of the eligible child's incapacity and dependency two (2) months before the date the dependent would otherwise cease to be covered.

We may require the same proof again, but We will not ask for it more than once a year after this coverage has been continued for two (2) years. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date We request proof which is not given to Us.

CLAIMS

Notice Of Claim. Written notice of claim must be given: (a) within 30 days after a covered loss begins; or (b) as soon as reasonably possible after that. This notice may be given to Us at Our Home Office or to Our Administrator. Notice should include the Covered Person's name and the Policy and Certificate numbers.

Claim Forms. When We receive notice of claim, We will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15-day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

Proof Of Loss. Proof of loss must be furnished to Us within 90 days after the date of loss. We will not deny or reduce a claim if it was not reasonably possible to give Us proof within the time allowed. In any event, the Covered Person must give Us proof within one (1) year after it is due unless he is legally incapacitated.

Time Of Payment Of Claims. Immediately after receiving written proof of loss, We will pay all benefits then due a Covered Person.

Payment Of Claims. All claims will be paid to You, unless We have the obligation to pay the facility or Provider directly. However, in the event a benefit becomes payable to Your estate, We may pay such benefit, up to an amount equal to $1,000, to any relative by blood or connection by marriage whom We deem to be equitably entitled thereto. Payment made in good faith fully discharges Us to the extent of any payments made.

Legal Actions. No legal actions may be brought to recover under the Policy: (1) within 60 days after written proof of loss has been furnished as required; or (2) after three years (five years in Kansas and six years in South Carolina) from when written proof of loss is required.

Claim Appeal Procedure. If We partially or fully deny a claim for benefits submitted by a Covered Person and he or she disagrees or does not understand the reasons for this denial, the Covered Person may appeal this decision, and they have the right to: 1) Request a review of the denial; 2) Review pertinent plan documents; and 3) Submit in writing, any data, documents or comments which are relevant to Our review of this denial.

The Covered Person's appeal must be submitted in writing within 180 days of receiving written notice of denial. We will review all information and send written notification within 60 days of the Covered Person's request.

GENERAL PROVISIONS

Entire Contract. The Policy is a legal contract. It is between the Policyholder and Us. The entire contract consists of: (1) the Policy, the Certificate, endorsements and attachments, if any; (2) the Policyholder's Application; and (3) the employees' enrollment forms, if any. Any statement made by the Policyholder or by a Covered Person in an application will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application is furnished the Covered Person.

Modification Of Policy. The Policy may be modified at any time by agreement between the Policyholder and Us without consent of any employee. No modification will be valid unless approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

Incontestability. The validity of the Policy shall not be contested except for non-payment of premiums, fraudulent misstatements or material misrepresentations after it has been in force for two (2) years. Coverage under this Certificate shall not be contested except for non-payment of premiums or material misrepresentation after it has been in force for two (2) years. No statement, except fraudulent misstatements, made by You relating to: 1) Your insurability; or 2) The insurability of Your Dependents; shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two (2) years. Any such statement must be contained in a written instrument signed by You, a copy of which has been furnished to You.

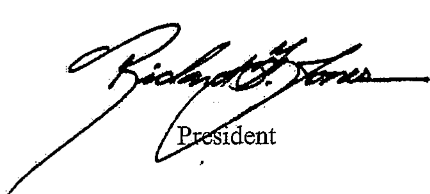
Fraud. If You or the Policyholder commits fraud pertaining to an employee against Us, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

Misstatement Of Age. If a Covered Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age. If a Covered Person's correct age was over the maximum issue age, coverage will be voided and the premiums paid for such Covered Person will be refunded.

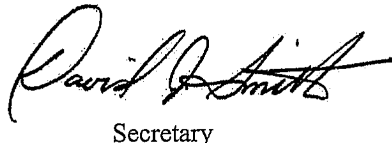
Assignment Of Benefits. You may assign Your benefits. However, an assignment is not binding until We have received and acknowledged in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Grace Period. A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. If the premium is not paid within the grace period, coverage will terminate as of the premium due date. The grace period will not apply if the Covered Person gives written notice to Us of his or her intent not to continue this coverage.

FIDELITY SECURITY LIFE INSURANCE COMPANY



President



Secretary

SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by Fidelity Security Life Insurance Company is the Summary Plan Description required by the Employee Retirement Income Security Act (ERISA) of 1974 to be distributed to participants in the Plan. Please attach to your group insurance certificate.

Name of the Plan:	Cornell College Voluntary Vision Plan
Plan Number:	508
Name, address and zip code of the Sponsor of the Plan:	Cornell College 600 First Street West Mount Vernon, IA 52314-1098
E.I.N.:	42-0680335
Name, business address, zip code and business telephone number of the Plan Administrator:	Cornell College 600 First Street West Mount Vernon, IA 52314-1098 (319) 895-4000 The Plan Administrator is responsible for the administration of the Plan and is the designated agent for the service of legal process for the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of authorization and payment of Plan administrative expenses, selection of the insurance consultant, selection of the insurance carrier and assisting the carrier with the determination of the eligibility of individual claimants for receipt of benefits.
Type of Administration:	The Plan is administered directly by the Plan Administrator with benefits provided in accordance with provisions of the group insurance policy issued by Fidelity Security Life Insurance Company whose home office address is: 3130 Broadway Kansas City, MO 64111
Type of Plan:	The benefits provided under this Plan are: Voluntary vision benefits provided by Policy No. VC-16-60792-1009. All employees are given a Certificate of Group Insurance which contains a detailed description of these benefits. If your booklet or certificate has been misplaced, you may obtain a copy from the Plan Administrator.
Eligibility:	Full-time employees regularly scheduled to work at least 1,000 hours per year. Domestic Partners are eligible for coverage pursuant to rules adopted by the Employer and applied on a uniform basis to all covered employees.
Effective Date:	First day of the month on or after the employee's date of hire.
Termination:	Coverage will terminate on the last day of the month in which the covered employee's active employment is terminated. However, if the covered employee ceases active employment due to layoff or authorized leave of absence (including FMLA or military leave), participation may be continued pursuant to Employer rules applied on a uniform basis to all covered employees similarly situated.

Cost of Benefits: The costs are paid through employee contributions.

Plan Year End: 12/31

Authority to Amend Plan: Vice President for Business Affairs/Treasurer

Administration and Plan Administrator Authority: The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing. The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Benefit Services Administrator and Plan Administrator.
The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.

LOSS OF BENEFITS:

The Plan Administrator may terminate the policy or, subject to the insurance company's approval, may modify, amend or change the provisions, terms and conditions of the policy. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured Person or any other person referred to in the policy will be required to terminate, modify, amend or change the policy. See your Plan Administrator to determine what, if any, arrangements may be made to continue your coverage beyond the date you cease active work.

STATEMENT OF RIGHTS:

Participants of this Plan 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 (EBSA).

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 reasonable charges 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.

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 pre-existing 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 pre-existing condition exclusion for 12 months 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 thirty (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 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 was 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.

COBRA CONTINUATION COVERAGE:

This section contains information about your right to COBRA continuation coverage, which is a temporary extension of coverage of group health plan benefits that may be offered under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** For purposes of this "COBRA Continuation Coverage" section of the

SPD, the term "Plan" will mean, unless the context indicates otherwise, each Underlying Plan which constitutes a group health plan within the meaning of Section 733 of ERISA.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

The Plan Administrator is Cornell College, 600 First Street West, Mount Vernon, IA 52314, (319) 895-4000. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

For other Underlying Plans, qualified beneficiaries must elect and pay for COBRA continuation coverage. The continuation coverage premium may be up to 102 percent of the cost to the Plan for such period of coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the Employer or employee). The applicable COBRA premium will be computed and fixed before the beginning of a 12-month premium cycle selected by the Plan. The Plan may increase a qualified beneficiary's premium amount during this 12-month premium cycle only if the Plan has previously charged less than 102 percent (150 percent during a disability extension) of the cost to the Plan for similarly situated beneficiaries or the qualified beneficiary changes the coverage being received.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Cornell College and that bankruptcy results in the loss of

coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event, within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must send this notice to Cornell College, 600 First Street West, Mount Vernon, IA 52314, (319) 895-4000. The notice must include sufficient information to enable the Plan Administrator to determine from the notice the Plan, the covered employee and qualified beneficiary(ies), the qualifying event, and the date on which the qualifying event occurred. A notice that does not contain all of the required information will not be considered notice of a qualifying event. Failure to supplement the notice with the additional information necessary to meet the foregoing content requirements will result in the loss of the right to elect continuation coverage.

In the event that the Plan Administrator receives a notice from a qualified beneficiary relating to a qualifying event, determination of disability by the Social Security Administration, or second qualifying event regarding a covered employee, qualified beneficiary, or other individual and determines that the individual is not entitled to continuation coverage under Part 6 of Title I of the Act, the Plan Administrator will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. Otherwise, after the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date health coverage is lost.

The Trade Act of 2002 added a special COBRA election period for individuals who are deemed eligible for trade adjustment assistance benefits because of a job loss due to trade-related reasons (for example, jobs that are lost to overseas business or that are adversely affected by foreign imports). Individuals are deemed eligible for benefits by the U.S. Department of Labor (DOL) or state labor agencies through a certification process. The special election period applies to deemed eligible individuals who have not previously elected COBRA coverage, but only if the eligibility determination occurs within six months of the loss of health coverage. The special election period begins on the first day of the month that the individual becomes eligible for benefits. If COBRA coverage is elected under this special election period, it begins on the first day of the special period -- there is no "reach back" to provide COBRA coverage from the date that coverage was lost to the beginning of the new election period. The election period ends in 60 days or six months following the initial loss of coverage, whichever is earlier.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA

continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the original 18-month COBRA continuation coverage. If you receive a disability determination from the Social Security Administration prior to the occurrence of the qualifying event, you must provide written notice to the Plan Administrator of the disability determination within 60 days of the date on which the qualified beneficiary loses coverage under the Plan as a result of the qualifying event. **This notice should be sent to the Plan Administrator, Cornell College, 600 First Street West, Mount Vernon, IA 52314, (319) 895-4000.** The notice must include sufficient information to enable the Plan Administrator to determine from the notice the Plan, the covered employee and qualified beneficiary(ies), the disability, and the date of the disability and the date on which the disability was determined.

If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform the Plan Administrator of this determination within 30 days of the date it is made.

Different premium rules apply if coverage is extended to 29 months due to an individual being deemed disabled. In such cases, for months 19 through 29 of COBRA coverage (or months 19 through 36 for qualified beneficiaries who incur a second qualifying event during the disability extension period), the COBRA premium for coverage covering the disabled individual may be as much as 150 percent of the cost to the Plan for such period of coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first event not occurred. The extension is also available to a dependent child would have lost eligibility for coverage under the Plan had the first event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. This notice should be sent to the Plan Administrator, Cornell College, 600 First Street West, Mount Vernon, IA 52314, (319) 895-4000.**

Paying for Coverage

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. This payment must cover the period of coverage from the date of the COBRA election retroactive to the date of the loss of coverage due to the qualifying event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum 30-day grace period for payments. Regardless of the due date stated in the Plan, at the election of the payor, premium payments may be made in monthly installments. At its discretion, the Plan Administrator may also permit a qualified beneficiary to make payments at other intervals.

Payment is considered to be made on the date it is sent to the plan. If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage. If the amount of the payment made to the Plan is made in error but is not significantly less than the amount due, the plan will notify you of the deficiency and grant a reasonable period, but in no event less than 30 days, to pay the difference. The Plan is not obligated to send monthly premium notices. COBRA beneficiaries remain subject to the rules of the Plan and therefore must satisfy all costs.

The Trade Act of 2002 included a new federal tax credit that qualified beneficiaries can use to offset the cost of COBRA coverage. The COBRA tax credit, equal to 65 percent of the cost of COBRA coverage, only applies to workers who lose their jobs due to trade-related reasons. If the special tax credit is available, an eligible individual can have the credit forwarded to the Plan, and then pay the remaining 35 percent of the COBRA premium. The Plan will be responsible for seeking the premium balance from the government. If you have any

questions regarding the TAA, please contact the Health Care Tax Credit (HCTC) Customer Service department at (866) 628-4282. TDD/TYY callers, please call (866) 626-4282. Or visit the HCTC on the Web at http://www.irs.gov (IRS keyword: HCTC).

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members, or change in marital status. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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, you should contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.