SUMMARY PLAN DESCRIPTION
FOR THE
BLUFFTON UNIVERSITY
MEDICAL AND DENTAL CARE EXPENSE
REIMBURSEMENT PLAN

This Summary Plan Description explains the most important features of the Bluffton University Medical and Dental Care Expense Reimbursement Plan as of January 1, 2010. READ this booklet, SHARE its contents with other members of your family, and KEEP it for future reference. BUT NOTE: THIS IS A SUMMARY ONLY. In all cases, it is the actual Plan document that controls participants' rights and benefits. If you would like to see the Plan document, copies are available upon request.
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PART I

INTRODUCTION

Bluffton University (the "Employer") has adopted the Bluffton University Medical and Dental Care Expense Reimbursement Plan (the "Plan") to enable eligible employees to pay for certain unreimbursed medical and dental care expenses on a pre-tax basis. The amounts contributed to and reimbursed from the Plan are not subject to Federal and State income taxes (although the contributed amounts may be subject to some local taxes).

We believe this Summary Plan Description provides answers to most of the questions you might have about the Plan. If you ever have any question that is not answered by this document, please contact the Plan Administrator at the address listed on the last page.

PART II

PARTICIPATION

You may participate in the Plan on the first day of the calendar month coincident with or following the date you become an Eligible Employee. You are an Eligible Employee if you are either (i) a permanent instructional faculty member, (ii) a non-faculty salaried permanent employee, or (iii) an employee who is paid on an hourly basis, and you either are a full-time employee or are determined to be a not-less-than-half-time employee, as determined under the Employer's Full-time Equivalence Test. Even though you may qualify to participate in the Plan, participation is voluntary. If you don't want to participate, please contact the Plan Administrator at the address shown on the last page. If you are eligible to participate, you may elect to contribute a portion of your compensation to your Medical and Dental Care Expense Account. If you terminate employment with the Employer, you will no longer be eligible to participate in the Plan, except as provided by continuation of coverage (see Part III, below).
The Plan Year begins on January 1 and ends on December 31. During the month of August (the "Annual Election Period"), you may elect to participate in the Plan by making an election under the Employer's Flexible Benefits Plan to reduce your compensation and contribute such amounts to the Plan. You may also elect under the Flexible Benefits Plan to allocate all or a portion of your Flex Dollars to this Plan. The elections are made on an enrollment form (which may be obtained from the Plan Administrator) and must specify the portion of your compensation and the number of Flex Dollars you want to contribute to the Plan. However, you may not contribute more than $2,400 (your Flex Dollars included) to the Plan each Plan Year.

During the Annual Election Period, you may prospectively make, revoke or modify your Plan election, effective as of the first day of the following Plan Year, by completing an enrollment form and filing it with the Plan Administrator. However, you generally may not modify or revoke your Plan election during the Plan Year unless your desire to change your election is directly attributable to a "Change in Status" or other permissible event under Code Section 125 and its regulations and the Plan Administrator approves your request. The events that may allow you to change your benefit election during the Plan Year generally include the following: your marriage or divorce, the birth or adoption of a child, the death of a dependent covered under the Plan, a change in your spouse's employment status, a significant change in your or your spouse’s health coverage, your dependent ceases to be considered a dependent, you or your spouse become entitled to Medicare, or you take FMLA leave.

Please note that the Employer may alter or revoke your election if you are a highly compensated employee (as defined in Section 414(q) of the Internal Revenue Code of 1986, as amended (the "Code")) to satisfy applicable restrictions imposed by the Code.
Additionally, the Committee reserves the right to limit the maximum amount that may be allocated to your Account to satisfy any requirements imposed by the Code.

PART III

CONTINUATION OF COVERAGE

Unless the exception described in (vii) below applies, you, your spouse or dependents may have the right to purchase continued coverage under the Plan if your normal coverage ends due to certain “qualifying events.” A summary of continuation coverage qualifications and requirements is provided below.

(i) Eligibility. To purchase continuation coverage, you must:

1. Have been participating in the Plan at the time you lost your coverage;

2. Lose your coverage because of a qualifying event;

3. Elect to purchase continuation coverage within the time described below; and

4. Pay your contributions on a timely basis.

(ii) Qualifying Events. You, your spouse or dependents may be eligible to purchase continuation coverage if any of the following events cause you to lose your coverage:

1. The reduction in hours or termination for other than gross misconduct;

2. Death;

3. Divorce or legal separation;

4. Entitlement to Medicare; or

5. A child no longer qualifies as a dependent under the Plan.

(iii) Maximum Period for Continuation of Coverage. If continuation coverage is offered to you and you accept, you may continue your coverage under the Plan until the end of
the Plan Year (December 31). After the end of the Plan Year, your continuation coverage will end.

(iii) When Continuation of Coverage Ends. Continuation coverage ends on the earliest of:

1. The last day of the Plan Year;
2. The date, after you elect continuation coverage, on which you become covered under any other group health plan that does not apply a pre-existing condition to you;
3. The date you become entitled to Medicare benefits;
4. The first day of any month for which your contribution is over 30 days late; or
5. The date the Plan is terminated.

All rights to continuation coverage also end if you fail to pay the first premium payment within 45 days after the day you elect continuation coverage.

(v) Electing Continuation of Coverage. When the Plan Administrator is notified of your qualifying event, you will be sent a notice and an election form. You then have 60 days to return the completed election form to the Plan Administrator.

(vi) Payment Amounts. To purchase continuation coverage, you must continue to pay your elected monthly contribution amount plus a 2% additional fee. Since you will no longer be an employee, these contributions will be made on an after-tax basis. Each contribution is due on the first day of the month to which it applies. If any contribution is not received by the Plan Administrator within 30 days of the due date, your continuation coverage will terminate.
(vii)  **Exception to Continuation of Coverage.** Continuation coverage will not be offered to you if, as of the date of the qualifying event, your account balance is less than the amount that you must pay to continue your coverage for the remainder of the year. For example, assume employee Joe elected to contribute $2,000 to the Plan for the 2010 Plan Year, and therefore $166.66 was deducted from Joe’s paycheck each month and placed into his account. Joe terminated on February 30, 2011, and, as of that date, he has been reimbursed $1,500 from his account. Consequently, Joe has a balance of $500 for the remainder of the Plan year. In order to continue his coverage for the remaining 6 months of the Plan Year (Plan Year ends on December 31, 2011), Joe will have to make a payment of $170 ($166 + 2% continuation coverage fee) each month. Since it will cost Joe $1,020 (6 months x $170) to continue his coverage for the remainder of the year, while he only has a balance of $500, Joe will not be offered continuation coverage under the Plan.

**PART IV**

**PAYMENTS FROM YOUR ACCOUNT**

You will be reimbursed on a tax-free basis for Medical and Dental Care Expenses you incurred during the Plan Year. Medical Care Expenses are expenses you incur for the care of yourself, your spouse and your dependents for medical care but only to the extent those expenses are not incurred to pay insurance premiums or are reimbursed by any other plan. Dental Care Expenses are expenses you incur for the dental care of yourself, your spouse and your dependents, but only to the extent those expenses are not incurred to obtain or pay for insurance premiums or are reimbursed by any other plan.
You may apply for payment or reimbursement of Medical and Dental Care
Expenses in an amount up to the total amount which you elected to contribute to the Plan for the
Plan Year, minus any claims already reimbursed. For example, if you elect to contribute $2,400
to the Plan for the 2010 Plan Year and you have not been reimbursed for any claims until you
incur a medical expense of $2,000 in October 2010, you will be entitled to a full reimbursement
of your claim at that time.

Claims for payment or reimbursement shall be made by submitting a written
application to the Plan Administrator on a form supplied by the Employer. That application must
specify:

(a) the amount, date and type of expense for which
reimbursement is requested;

(b) the name of the individual on whose behalf the expense
was incurred;

(c) the name of the person or entity to whom the expense was
paid; and

(d) any other information required by the Employer.

The application also must be accompanied by original bills, invoices, receipts, canceled checks
or other statements showing the amounts of the expenses, together with any additional
substantiation the Employer may request. Please note that any unclaimed amounts remaining
in your Medical and Dental Care Expense Account after the end of the reimbursement
period for a Plan Year will be forfeited. Consequently, you should select your annual
contribution amount very carefully because you will lose the amounts you do not use.

All applications for payment or reimbursement must be submitted to the employer
no later than 60 days following the end of the Plan Year in which the claim was incurred
(currently by March 1st). Generally, if you submit an acceptable (completed, timely and fully-documented) claim during one payroll period, you should receive your reimbursement no later than the payroll date of the following payroll period.

Not later than January 31 of each calendar year, you will receive a written statement showing the amounts paid to you from your Medical and Dental Care Expense Account during the prior calendar year.

PART V

CLAIMS AND APPEALS PROCEDURES

If your claim under the Plan is denied, the Committee will provide you with written notice stating why your claim was denied within 30 days of the date your claim was filed, or within 45 days if a delay is needed for reasons beyond the Plan’s control. Upon receipt of the Committee's written notice or if the Committee does not respond to your claim within 30 days, you may appeal the decision by filing a written appeal to the Committee. That appeal must be delivered to the Committee within 180 days after receiving the Committee's written notice denying the claim. The Committee will designate a sub-committee that did not participate in your initial claim decision to rule on your appeal. The sub-committee will decide your appeal within 60 days. You may appear before the sub-committee to present your claims. The final decision will be in writing and will clearly state the reason for the Plan’s decision.

PART VI

AMENDMENT AND TERMINATION

While the Employer expects to continue the Plan, it reserves the right to amend or terminate the Plan at any time. However, the Plan may not be amended or terminated with
respect to any claims that were incurred before the date of the applicable amendment or
termination, except that the Employer may amend the Plan to comply with any laws or
regulations relating to tax-qualified retirement plans or trusts, even if that amendment reduces
benefits you already have earned.

PART VII

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, you may not be forced to cover someone under the Plan. However, the
law does require you to cover your child if a Qualified Medical Child Support Order requires it
(a “QMCSO”). A QMCSO is a court-ordered judgment, decree, or property settlement that
creates a child’s right to be covered under the Plan or enforces certain laws relating to medical
child support. The Plan Administrator will determine whether an order is a QMCSO. Upon
request, a free copy of the Plan’s QMCSO procedures may be obtained from the Employer.

PART VIII

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT STATEMENT

Group health plans and health insurance issuers generally may not, under federal
law, restrict benefits for any hospital length of stay in connection with childbirth for the mother
or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours
following a cesarean section. However, federal law generally does not prohibit the mother’s or
newborn’s attending provider, after consulting with the mother, from discharging the mother or
her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may
not, under federal law, require that a provider obtain authorization from the plan or the issuer for
prescribing a length of stay not in excess of 48 hours (or 96 hours).
PART IX

MISCELLANEOUS

Neither the creation of the Plan nor any amendment to it gives any legal or equitable right to any person against the Employer, its officers or employees, except as provided in the Plan. All liabilities under the Plan will be satisfied, if at all, only through the Plan. Participation in the Plan does not give any Participant any right to continued employment. The Plan will be construed and enforced according to the laws of the State of Ohio to the extent those laws are not preempted by federal law.

PART X

YOUR ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

1. Examine, without charge, at the Plan administrator's office all documents governing the Plan 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 Pension and Welfare Benefits Administration.

2. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
3. 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 continuation coverage rights.

If you have creditable coverage from another plan, exclusionary periods of coverage for preexisting conditions may be reduced or eliminated. You should be provided a certificate of 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 continuation coverage, when your 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining
your vested rights in your accrued benefits under the Plan or for exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for benefits under the Plan 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 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 which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA,
you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

PART XI

GENERAL PLAN INFORMATION

A. PLAN NAME: Bluffton University Medical and Dental Care Expense Reimbursement Plan.

B. PLAN NUMBER AND EMPLOYER EIN#: 502/34-4428207.


D. PLAN YEAR: January 1 through December 31.

E. PLAN ADMINISTRATOR AND EMPLOYER:

   Bluffton University Medical and Dental Care Expense Reimbursement Plan Committee
   1 University Dr.
   Bluffton, Ohio 45817-2104
   TELEPHONE: (419) 358-3000

F. TYPE OF ADMINISTRATION

   Self-Administered.
G. AGENT FOR RECEIPT OF LEGAL PROCESS:

Bluffton University Medical and
Dental Care Expense Reimbursement
Plan Committee
1 University Dr.
Bluffton, Ohio  45817-2104

TELEPHONE:  (419) 358-3000