SAINT MARY'S COLLEGE FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

December 2003

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Saint Mary's College (the "Employer") is pleased to sponsor an employee benefit program known as the "Saint Mary's College Flexible Benefits Plan" (the "Plan") for you and your fellow employees. It is so-called because it lets you choose from several different insurance and fringe benefit programs according to your individual needs. The Employer provides you with the opportunity to use pre-tax dollars to pay your share of the cost of the benefit programs by completing an enrollment form. This arrangement helps you because the benefits you elect are nontaxable; you save social security and income taxes on the amount of your contributions. Alternatively, to the extent described in your enrollment materials, you may choose to pay for any of the available benefits with after-tax contributions.

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. The booklet is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. It is not a part of the official plan documents. If there is a conflict between the plan documents and this booklet, the plan documents will govern.

Q1. What benefits can I purchase on a pretax basis through the Plan?

You may choose to participate in the Plan and pay the premiums for the component Benefit Package Options with pre-tax contributions by filling out any required enrollment form(s). The applicable Benefit Package Options are listed in annual open enrollment materials. You may also receive reimbursements for uninsured medical care expenses and or dependent care expenses with pre-tax contributions. The various benefit options available to you under the Plan will be described to you in information materials distributed prior to each enrollment period.

Q2. Who can participate in the Plan?

Each full-time and part-time Employee who is eligible for the Saint Mary's College Group Insurance Plan is eligible for participation in this Plan. Those employees who actually participate in the Plan are called "Participants". An employee continues to participate until he or she: i) elects not to participate; or ii) is no longer employed by the Employer, or Continuation Coverage (as described below) is no longer in effect.

Q3. What tax advantages are available through the Plan?

Suppose your monthly gross pay is $2,500 per month and your cost for coverage is $140.00 per month. Also, suppose your total withholdings (income tax and Social Security) are 22.65%. After paying for coverage from your after-tax pay, your take home pay is $1,794.00. However, under the Plan, you will be considered to have received $2,360.00 in pay rather than $2,500 with $140.00 contributed for medical coverage. This means your take home pay will be $1,825.00 with the Plan rather than $1,794.00 without it. Thus, you save $31.00 per month ($372.00 per year) by participating in the Plan. The Table below illustrates this savings.

	WITH PLAN	WITHOUT PLAN
Gross Monthly Pay	$2,500.00	$2,500.00
Pre-Tax Coverage Under Plan	$140.00	0.00
Taxable Income	2,360.00	2,500.00
Estimated Federal Tax (15%)	354.00	375.00
FICA Tax	181.00	191.00
After-Tax Coverage	0.00	140.00
Take-Home Pay	**$1,825.00**	**$1,794.00**

Q4. How do I become a participant?

You become a Participant by signing an enrollment form on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You will be provided an enrollment form when you first become eligible to participate. You must complete the form and return it to the Human Resources Office within 31 days of your date of hire. If you fail to make a timely election, you are deemed to have elected to receive your entire cash compensation for the Plan Year.

In future years, a new enrollment form will be made available to you during the annual open enrollment period, and you will be given the opportunity to confirm or change your choices for the next Plan Year.

A Participant who fails to complete, sign and file an enrollment form as required shall be deemed to have elected to continue participation in the health, dental and/or vision Plans with the same benefit elections as during the prior Plan Year (adjusted to reflect any increase/decrease in applicable premiums), and (except for a Change in Status) will not be permitted to modify his election until the next Annual Enrollment Period.

Notwithstanding the foregoing, annual elections for participation in the Medical Care Expense Reimbursement and Dependent Care Expense Reimbursement Plans must be made each year by submitting an enrollment form prior to the beginning of each plan year - no deemed elections shall occur with respect to such benefits.

Q5. Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the pre-tax premium payment option or vary the pre-tax premiums you have selected during the Plan Year, although your election will terminate if you are no longer working for the Employer. Otherwise, you may change your elections only during the annual open enrollment period, and then, only for the coming Plan Year.

There are several important exceptions to this general rule: You may change or revoke your previous election for pre-tax premiums during the Plan Year if you file a written request for change with the Plan Administrator within 30 days of any of the following events:

1. **Change in Status.** If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and

new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as Changes in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your Spouse);

- a change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

- any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student); and

- a change in your, your Spouse's or your Dependent's place of residence which affects eligibility for coverage.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for pre-tax premiums within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for Dependent Care Expense reimbursement, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage and Medical Care Expense Reimbursement benefits), a special rule governs which type of election changes are consistent with a Change in Status. For a Change in Status involving your divorce, annulment or legal

separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

However, if you, your Spouse, or a Dependent elect COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution to pay for such coverage.

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

- *Dependent Care Expense Reimbursement Benefits*. With respect to the Dependent Care Expense Reimbursement benefit, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000

during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the Plan Administrator notifies you that the cost of your coverage under the Plan *significantly* increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and receive coverage under another Benefit Package Option which provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the

requirements of this section are met. (Please note that none of the above "Change in Cost" exceptions are applicable to Medical Care Expense Reimbursement accounts under the Plan.)

> Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Package Option that provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by a new or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage. The Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. (Please note that none of the above "Change in Coverage" exceptions are applicable to Medical Care Expense Reimbursement accounts under the Plan.)

Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q6. What if I terminate my employment during the Plan Year?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan unless you do so on an after-tax basis.

Q7. What is a "Health Care Reimbursement Account" and what is the annual limit?

If you elect benefits under this portion of the Plan, a non-interest bearing Health Care Reimbursement Account ("Account" or "Health FSA") will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year. You may choose any amount of Plan Year reimbursement you desire up to $2,000 - the maximum annual reimbursement amount.

When you complete the enrollment form, you specify the pre-tax amount you wish to contribute to your Account with pre-tax salary reductions. Thereafter, you contribute to your Account by having an equal portion of the annual contribution deducted from each paycheck on a pre-tax basis. The full amount of the coverage you have elected will be available to reimburse you for your out-of-pocket medical expenses at any time during the Plan Year, so long as you continue to pay the premiums, reduced however by the amount of prior reimbursements received during the Year.

For example, suppose you have elected to be reimbursed for up to $1,000 per year for Eligible Medical Expenses, and you have chosen no other benefits under the Plan. Your Account would be credited (and funded) with a total of $1,000 during the Plan Year. If you are paid bi-weekly, your Account would reflect that you have contributed $38.46 per pay period towards the benefit you have elected.

Q8. How do I receive Health Care Reimbursements under the Plan?

If you elect to participate in this portion of the Plan, you will have to take certain steps to be reimbursed for your Eligible Medical Expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. You must include written statement(s)/bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s) along with the Claim Form. In addition, you must include an Explanation of Benefits (EOB) Form(s) from any primary medical and/or dental insurance carrier(s) indicating the amount(s) that you are obligated to pay.

You will be reimbursed for your Eligible Expenses as soon as administratively possible following submission of the claim. Remember, though, you can't be reimbursed for any expenses that exceed the annual reimbursement amount you have elected.

You will have until March 31st of the following year in which to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year. If you terminate employment, you may continue to submit claims for reimbursement of Eligible Expenses incurred before your date of termination to the extent you had a positive Account balance on your date of termination. You will be notified in writing if any claim for benefits is denied.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for an Eligible Medical Expense -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

Q9. What is an "Eligible Expense" under the Health Care Reimbursement Account?

An "Eligible Expense" means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return (without regard to any threshold limitation) for which you have not otherwise been reimbursed from insurance, or some other source. Premiums for accident or health insurance coverage under any other plan are not Eligible Medical Expenses. Also, expenses for long-term care services are not eligible.

Generally, costs related to medical care (i.e., amounts paid for diagnosis, cure, mitigation, treatment or prevention of a disease, or for the purpose of affecting any structure or function of the body), as well as the costs of equipment and supplies (such as crutches and bandages which mitigate the effect of an injury, diagnostic devices such as blood sugar test kits). Below is a list of the types of health care expenses eligible for reimbursement. There may be other expenses eligible for reimbursement. If you have any questions regarding the eligibility of a particular health care expense, you are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an eligible expense if you have any doubts.

EXAMPLES OF HEALTH CARE EXPENSES ELIGIBLE FOR REIMBURSEMENT

EQUIPMENT AND SUPPLIES

Abdominal Supports
Arches
Artificial Limbs
Back Supports
Braces
Elastic Hosiery
Hearing Aids and Batteries
Invalid Chair
Orthopedic Shoes (excess cost over normal shoes)
Oxygen
Repair of special telephone equipment for the deaf
Wigs (advised by a doctor as essential to mental health of a person who has lost all their hair from disease)
Wheel Chair
X-Rays

MEDICAL TREATMENTS

Acupuncture
Body/heart scans
Chiropractic care
Drug and alcoholism treatment
Hydrotherapy (water treatments)
Psychiatric care and psychologist fees

DENTAL SERVICES (if not covered under the Dental Plan)

Artificial Teeth
Bridges
Crowns
Dentures
Fluoride Treatments

Fees
Teeth cleanings
Orthodontia

VISION CARE EXPENSES

Contact lenses
Eyeglasses
Optometric Examinations
Radial Keratotomy and LASIK procedures

MISCELLANEOUS

Braille Books (excess cost over regular books)
Co-insurance or Co-payments
Deductibles
Over the counter medicines and prescription drugs (e.g., antacid, allergy medicine, pain reliever and cold medicine)
Kidney Donor's expenses
Nurse's board and wages, including Social Security taxes
Remedial reading for children with dyslexia
Sanitarium and similar institutions
Seeing-eye dog and its maintenance
Special school costs for physically or mentally handicapped children
Telephone-teletype costs and television adaptor for closed captioned service for the deaf
Wages for guide for blind person

EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Athletic club expenses to keep physically fit
Babysitting fees to enable you to make doctor's visits
Boarding school fees for healthy children
Bottled water
Cost of trips for change of environment (even if recommended by doctor)
Dance lessons
Funeral, cremation or burial expenses, burial plot or mausoleum
Maternity clothes
Premiums for health insurance policies
Special food or beverages (however, the difference in cost between special foods and normal food is eligible in certain cases)
Toothpaste and Teeth Whitening
Veterinary fees for pet
Vitamins, tonics, cosmetics, etc. (even if prescribed by a doctor)
Birth Control
Abortion
Voluntary Sterilization

Q10. When must the medical care expenses be incurred for which I may be reimbursed?

Eligible Expenses relating to medical care must have been incurred during the Plan Year. An expense is incurred when the medical treatment relating to the expense is rendered (regardless of when the expense has been billed or paid for). You may not be reimbursed for any expenses arising before the Plan became effective, before your enrollment becomes effective, or for any expenses incurred after the close of the Plan Year, or, after a separation from service (unless you elect to continue coverage pursuant to COBRA).

Q11. What if the medical expenses I incur during the Plan Year are less than the annual amount I have elected for Health Care Reimbursement?

Any money in your Health Care Reimbursement Account that is not used to reimburse you for qualified expenses during the Plan Year ***cannot*** be returned to you. For this reason, you may want to contribute only enough to pay for out-of-pocket expenses that you are reasonably sure you will incur, such as plan deductibles, co-payments, and procedures that are not covered by a group health plan or individual insurance policy. Amounts so forfeited shall be used to offset administrative expenses and future costs.

Q12. What is my Dependent Care Reimbursement Account and what is the maximum limit?

If you elect benefits under this portion of the Plan, a non-interest bearing Dependent Care Reimbursement Account ("Account") will be set up in your name to keep a record of the reimbursements you are entitled to.

This amount cannot exceed the maximum amount specified in Section 129 of the Internal Revenue Code. The maximum amount is currently $5,000 per Plan Year if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care Reimbursement Account, your Spouse maintains a separate residence for the last 6 months of the calendar year, and you file a separate tax return; or
- are single, or are the head of household for tax purposes.

If you are married, reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement Account benefit you may elect is $2,500.

Q13. How is my Dependent Care Reimbursement Account funded?

When you complete the enrollment form, you specify the amount you wish to contribute to your Account with pre-tax salary reductions. Thereafter, you will contribute to your Account by having an equal portion of the annual contributions deducted from each paycheck on a pre-tax

basis. For example, suppose you have elected to be reimbursed for $2,600 per year for Eligible Employment Related Expenses, and you have chosen no other benefit under the Plan. Your Account would be funded with a total of $2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of $100.00 credited to your Account each payday to pay reimbursements under this Plan. The amount that is available to your Account at any particular time will be whatever has been credited to such Account less any reimbursements already paid.

Q14. What is an "Eligible Expense" for dependent care which I can claim a reimbursement?

You may be reimbursed for work-related expenses incurred on behalf of any individual in your family who is under age 13 who resides with you and for whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically incapable of caring for himself or herself; or your Spouse, if the Spouse is physically or mentally incapacitated.

Generally, these expenses must meet all of the following conditions for them to be Eligible Dependent Care Expenses:

1. The expenses are incurred for services rendered after the date of your election to receive Dependent Care Expense Reimbursement, and during the calendar year to which it applies.

2. Each individual for whom you incur the expenses is

   (a) a Dependent age 12 or under for whom you are entitled to a personal tax exemption as a dependent, or

   (b) a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.

3. The expenses are incurred for the care of a Dependent (as described above), or for related household services, and are incurred to enable you to be gainfully employed. Expenses for overnight stays or overnight camp are not eligible. Tuition expenses for kindergarten (or above) do not qualify.

4. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent regularly spends at least 8 hours per day in your home.

5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a dependent.

7. This reimbursement (when aggregated with all other Dependent Care Reimbursements during the same year) may not exceed the least of the following limits:

   (a) $5,000.

   (b) $2,500, if you are married but you and your Spouse file separate tax returns.

   (c) Your taxable compensation (after your contributions to this Plan).

   (d) If you are married, your Spouse's actual or deemed Earned Income.

   For purposes of (d) above, your Spouse will be deemed to have Earned Income of $200 ($400 if you have two or more Dependents described in paragraph 2 above), for each month in which your Spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time Student.

8. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q15. How do I receive reimbursement for Dependent Care Expenses under the Plan?

If you have elected to participate in this portion of the Plan, you will have to take certain steps to be reimbursed for your Eligible Employment Related Expenses. When you incur an expense that is eligible for payment, you submit a claim to the Plan's Administrator on a Claim Form that will be supplied to you. If there is a sufficient balance in the Dependent Care Expense Reimbursement Account, you will be reimbursed for your eligible expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your curent Account balance. You may not be reimbursed for any expenses that arise before your enrollment becomes effective, or for any expense incurred after the close of the Plan Year.

To have your claims processed as soon as possible, please read the claims instructions you have been furnished. Please note that it is not necessary that you have actually paid an amount due for Eligible Employment Related Expenses -- only that you have incurred the expense, and that it is not being paid for or reimbursed from any other source.

In addition, you will have until March 31st of the following year in which to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year. In addition, you may submit a claim for reimbursement of Eligible Expenses if the claim was incurred before the date that you terminate your employment so long as the claim was incurred during the Plan Year in which you terminated employment and you submit the claim before March 31st following the end of the Plan Year in which you terminated. You will be notified in writing if any claim for benefits is denied.

Q16. What if the Eligible Employment Related Expenses I incur during the Plan Year are less than the annual amount of coverage I have elected for Dependent Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related Expenses you have incurred, on the one hand, and the annual coverage you have elected and paid for, on the other. Any amount allocated to an Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide the elected reimbursement for any Plan Year before the end of the Extension Period following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be used to offset reasonable administrative expenses and future costs.

Q17. Will I be taxed on the Dependent Care Reimbursement Account benefits I receive?

You will not normally be taxed on your Dependent Care Reimbursement Account benefits, up to the limits set forth above. However, to qualify for tax-free treatment, you will be required to list on your annual tax return the names and taxpayer identification numbers of any individuals who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

Q18. If I participate in the Dependent Care Reimbursement Account, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the balance of your qualified dependent care expenses may be eligible for the dependent care credit.

Q19. What is the household and dependent care credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Dependent, or $6,000 for two or more Dependents. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of $900 for one Dependent or $1,800 for two or more Dependents,) to a minimum of 20% of such expenses (producing a maximum credit of $600 for one Dependent or $1,200 for two or more Dependents.) The maximum 30% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $10,000.

Illustration: Assume you have one Dependent for whom you have incurred Eligible Expenses of $3,600. Also assume that your adjusted gross income is $20,000. Since only one Dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 30% for each $2,000 of your adjusted gross income over $10,000. The calculation is: 30% -- [($20,000 - 10,000)/$2,000 X 1%] = 25%. Thus, your tax credit would be $3,000 X 25% = $750. If you had incurred the same expenses for two or more Dependents, your credit would have been $3,600 X 25% = $900, because the entire expense would have been taken into account, not just the first $3,000.

Q20. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q21. What happens if a claim for benefits is denied?

If your claim is for a benefit under one of the component Benefit Package Options you will generally proceed under the claims procedure applicable under the component Benefit Plan or Policy. However, if you are denied a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under this Plan (i.e., such as a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Cafeteria Plan document), the claims procedure under this Plan will apply, and you will be notified in writing by the Plan's Administrator within 90 days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim; you may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

Q22. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your Spouse and Dependents' right, to continue to be covered under any of the component medical benefit plans if participation by you (including your Spouse and Dependents) otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- ♦ termination of your employment (other than by reason of gross misconduct), or reduction of your work hours;
- ♦ your death;
- ♦ divorce or legal separation from your Spouse;

- your becoming entitled to receive Medicare benefits;
- when a dependent of yours ceases to be a dependent.

For a Qualifying Event, other than a change in your employment status, it will be your obligation to inform the appropriate Plan Administrator of each medical benefit plan you have elected within 60 days of the occurrence. The appropriate Plan Administrator, in turn, has a legal obligation to furnish you, or your Spouse, as the case may be, with separate, written options to continue the coverage provided at stated premium costs with respect to each health plan in which you are a participant. The notification you will receive will explain all the rest of the terms and conditions of the continued coverage.

Certain Medical Care Expense Reimbursement Account Participants will be eligible for COBRA Continuation Coverage if they have a positive Medical Care Expense Reimbursement Account balance (taking into account all submitted claims) at the time of a Qualifying Event. You will be notified if you are eligible for COBRA Continuation Coverage.

Q23. What is the Family and Medical Leave Act?

If your Employer is subject to the Family and Medical Leave Act ("FMLA") (generally, employers with at least 50 employees) and you are on eligible leave under FMLA, you may continue to pay for your health insurance coverage provided by the component medical plans on an after-tax basis, or alternatively, via another arrangement as described in the enrollment materials. If your Employer pays a portion of your medical premiums, it must continue those payments. However, if you do not return from FMLA, you may be required to repay the Employer-paid portion of the medical premiums. If your Employer is subject to FMLA, you should be provided with a complete explanation of your FMLA rights and responsibilities.

Q24. What are my rights under ERISA?

The Cafeteria Plan is not an ERISA welfare benefit plan. However, the component Benefit Package Options may be governed by ERISA. As a Participant in an ERISA-covered benefit, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("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 work-sites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health coverage for your self, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, may not be applicable if you have creditable coverage 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 (18 months for late enrollees) after your effective enrollment date applicable to your new 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, 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 Plan 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 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 the 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 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.

Q25. OTHER REQUIRED PLAN INFORMATION

Plan Administrator/Employer/Company

Saint Mary's College, Notre Dame, IN 46556

Service of Legal Process should be made through the Director of Human Resources, Saint Mary's College, Facilities Building, Notre Dame, IN 46556.

Plan Effective Date: Effective January 1, 2004

Employer Identification Number: 35-0868158

Plan Number: 502

Plan Funding and Contributions: The Plan is self-funded by the College using the College's general assets from contributions from participating employees.

Plan Type: A section 125 plan to fund medical and dependent care expenses for flexible spending accounts on a pre-tax basis as well as pay for insurance premiums on a pre-tax basis.

Type of Plan Administration - The College administers all aspects of the Plan including claims.

Plan Year: January 1 through December 31.

This description is a general summary of the principal provisions of the Saint Mary's College Flexible Benefits Plan. The actual provisions are contained in the Plan document, which is legally binding. If there are inconsistencies between this Summary Plan Description and the Plan document, the Plan document will govern. You can examine a copy of the Plan during regular business hours.

Supplement to the
Saint Mary's College Flexible Benefits Plan
Summary Plan Description

It has come to our attention that the following information was inadvertently not included in the Summary Plan Description dated December 2003. Please retain this supplement with your copy of the Summary Plan Description.

The list of examples of Health Care Expenses on page 9 are Not Eligible for Reimbursement under the Plan, should have included the following items/procedures and expenses relating thereto which are specifically excluded: Birth Control, Abortion and Voluntary Sterilization.