ST. OLAF COLLEGE
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

This booklet describes the basic features of the St. Olaf College Flexible Benefits Plan, and along with annual enrollment materials provides important information regarding the Plan. 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.

A capitalized term means there is a precise definition of that term in this summary. These definitions are solely for the purpose of helping you understand this summary, and may not apply to other benefit plans or programs offered though the College.

Except as otherwise indicated for specific sections, this amended and restated Summary Plan Description is effective as of April 2012.

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THE PURPOSE AND TYPE OF PLAN

The purpose of the St. Olaf College Flexible Benefits Plan (the “Plan”) is to allow Eligible Employees of St. Olaf College (the “College”) to convert some of their income to pay for certain benefits on a pre-tax basis. This is a flexible benefit plan that permits participants to choose among more than one benefit. It is classified as a “cafeteria plan” for federal income tax purposes.

ELIGIBILITY TO PARTICIPATE

If you are an Eligible Employee, you may elect to become a participant in the Plan on the first day of the first month coinciding with or immediately following your date of hire by satisfying the participation conditions.

Eligible Employee - You are an Eligible Employee if you are a common law employee of the College whose term of employment is anticipated to be 6 months or more, except, that the following are not Eligible Employees under the Plan:

1. Persons covered by a collective bargaining agreement to which the College is a party, unless such collective bargaining agreement expressly provides for inclusion of such persons in the Plan;

2. Leased employees;

3. Persons classified by the College as independent contractors, contract workers, temporary employees or casual workers;

4. Nonresident aliens who receive no earned income from the College that constitutes income from sources within the United States.

As discussed in greater detail below, each benefit offered through the Plan is subject to specific FTE requirements and eligibility requirements. An Eligible Employee may not be eligible for all benefits offered through the Plan. The requirements for each benefit must be met before you will be covered by that benefit, and the terms and conditions applicable to that benefit will apply.

FTE – Full Time Equivalency. FTE status is determined for nonfaculty employees on the basis of 2080 hours per year which equals an FTE of 1.0. For faculty employees, FTE status is determined on the basis of 6 courses per year which equals an FTE of 1.0.

CONDITIONS OF PARTICIPATION

As a condition to participation in the Plan and to receiving reimbursement benefits under this Plan, you must:

(1) Be eligible for each particular benefit in relation to which you seek to participate and receive benefits;
(2) Execute and deliver to the College, within 30 days of becoming eligible to participate in the Plan, an application to participate in the Plan and a benefit election form;

(3) Authorize Salary Reduction Contributions in the required amount;

(4) Observe all Plan rules and regulations;

(5) Agree to inquiries by the College with respect to services covered by this Plan; and

(6) Submit to the College all reports, bills, and other information that the College may reasonably require.

If you do not make a benefit election within the time period required by the Plan, you may not be eligible to participate in the Plan.

**PAYING FOR YOUR BENEFITS**

Benefits provided under the Plan are paid for by you through your Salary Reduction Contributions.

*Salary Reduction Contributions* - The amounts by which you reduce your regular gross (before tax) wages or salary in exchange for the College’s contribution of equal amounts to the Plan. These Salary Reduction Contributions are used to pay the employee cost of the Benefits you elect under the Plan.

You authorize Salary Reduction Contributions by signing the application to participate. The College will tell you what the cost of premiums is each year.

You will determine annually the amount of Salary Reduction Contributions you want withheld to pay for health care reimbursement and dependent care reimbursement expenses.

**DESCRIPTION OF BENEFITS**

The types of benefits available to you under the Plan are described below.

For each Plan Year, the College will determine the benefits (if any) that you may elect to receive under the Plan, your cost for the benefits, and what elections you may make. The College will provide you with this information prior to the time you must make your benefit election for each Plan Year.

The types of benefits available to you under the Plan are listed below. If you are an Eligible Employee, you may elect to receive these benefits upon becoming a Plan participant. Once you satisfy the FTE requirement and other eligibility requirements applicable to the benefit and elect to receive the benefit, you will be covered as of the date described below. You must use your
Salary Reduction Contributions to pay the employee cost of these benefits. If you do not use your Salary Reduction Contributions to purchase benefits, such amounts will be paid to you as salary.

1. **Comprehensive Major Medical Plan Coverage.** Payment of the employee cost of coverage under the Comprehensive Major Medical Plan. An Eligible Employee with an FTE of at least 0.50 may elect single, single plus one or family coverage under the Comprehensive Major Medical Plan as a benefit. Please refer to the Comprehensive Major Medical Plan Summary Plan Description for additional information.

2. **Dental Plan Coverage.** Payment of the employee cost of coverage under the Dental Plan. An Eligible Employee with an FTE of at least 0.50 may elect single, single plus one or family coverage under the Dental Plan. Please refer to the Dental Plan Summary Plan Description for additional information.

3. **Medical Care Reimbursement Benefit.** All Eligible Employees with an FTE are eligible to elect Medical Care Reimbursement benefits.

If you elect medical care reimbursement coverage, you can use your available Salary Reduction Contributions to be reimbursed for eligible health care expenses incurred during the Period of Coverage for that Plan Year that are related to the diagnosis, treatment, or prevention of disease or for sickness and injury. Expenses that are generally eligible are such costs as deductibles, co-payments, and out-of-pocket expenses related to the health care you receive. If you elect to receive health care reimbursement coverage, you will elect your level of coverage for the Plan Year within the Plan’s limits. The maximum level of coverage is $5,000 per Plan Year. Beginning September 1, 2013, the maximum level of coverage is $2,500 per Plan Year. If you join the Plan midyear, the maximum may be prorated.

The following list gives examples of the types of medical expenses that may be reimbursed through the Plan:

- Surgical services
- Hospital services
- Laboratory services
- Prescription medicine and drugs
- Ambulance services
- Pre-natal care
- Orthodontia
- Vision care
- Contact lenses
- Seeing eye dogs
- Tape recorders for blind persons
- X-Ray treatments
- Nursing services
- Dental services
- Insulin
- Chiropractic and osteopathic services
- Chemical dependency services
- Psychiatric care
- Prescription eyeglasses
- Hearing aids
- Wheelchairs
- Crutches
Premiums for insurance coverages and similar expenses (e.g., payments for HMO coverage) are **not** reimbursable. In addition, effective January 1, 2011, certain Over-the-Counter medications like aspirin and Tylenol are not reimbursable unless you have a doctor’s prescription. However, non-medications that can be obtained without a prescription, such as bandages, continue to be eligible for reimbursement. Please contact SelectAccount if you have questions about reimbursable medical expenses. Finally, health care expenses that either will be covered by any health or accident plan or insurance policy or for which you may be reimbursed from another source are **not** reimbursable. SelectAccount can be contacted as follows:

SelectAccount Customer Service, 800-859-2144 or 651-662-5065  
Monday - Friday, 7:00 am to 7:00 pm (Central Time)  
Fax: 651-662-7247 or 866-231-0214

If you have any questions about whether an expense can be reimbursed from the Plan, you should contact the Human Resources Department.

As explained under SPECIAL RULES RELATING TO REIMBURSEMENT BENEFITS, you can be reimbursed only for expenses incurred during your Period of Coverage for that Plan Year.

In addition, no health care expense will be reimbursed under this Plan to the extent that either the expense is covered by any health or accident plan or insurance policy or you will be reimbursed for the expense from another source.

EXAMPLE 1: Assume that you have a routine eye exam for which the physician charges you $50, and you subsequently purchase eyeglasses as prescribed by the physician for $75. If neither expense is covered by an insurance policy, the full $125 would be eligible for reimbursement.

EXAMPLE 2: Assume that, while you are a participant, you become ill and are hospitalized, incurring expenses of $1,500 of which insurance pays $1,100 and the remaining $400 is applied toward your deductible or was not paid because the insurance pays only a portion of your expenses. This $400 would be eligible for reimbursement. Medical reimbursement benefits are only intended to cover items not paid for by insurance or reimbursed by another source.

If you elect to receive health care reimbursement coverage, you will elect your maximum level of coverage for the Plan Year, up to a limit of $5,000. Beginning September 1, 2013, the maximum limit is $2,500.

For example, if you elect a Plan Year limit of $600, you can claim reimbursement for up to $600 of eligible medical expenses incurred during your Period of Coverage for the Plan Year. You may be reimbursed for eligible medical expenses up to your $600 maximum level of coverage at any time during the Plan Year. For example, if you elect $600 of medical reimbursement coverage for the Plan Year and incur $580 of eligible medical
expenses in January, the full $580 will be eligible for reimbursement upon your making a proper claim.

4. **Dependent Care Reimbursement Expenses.** Eligible Employees with an FTE may also set aside available Salary Reduction Contributions in a dependent care reimbursement account. This account can be used to reimburse you for amounts paid for the care of a Qualifying Individual or for household services attributable in part to the care of the Qualifying Individual, if those amounts are paid to permit you to be gainfully employed during a period for which there is a Qualifying Individual with respect to you. If expenses are incurred outside of your household, they will be eligible for reimbursement only if they are incurred for the care of a Qualifying Individual under the age of 13 or a Qualifying Individual that spends at least 8 hours per day in your household. In addition, if the expense is incurred outside your home at a facility that provides care for more than 6 individuals that do not regularly live in the facility, the facility must comply with all applicable state and local laws and regulations, including any applicable licensing requirements.

**Qualifying Individual** - The term “Qualifying Individual” means any individual in your family who is under the age of 13, who resides with you and whom you can claim as a dependent on your tax return, or your spouse or any other dependent who is mentally or physically incapable of self-care. However, an exception may apply if you are divorced or separated. Under the exception, if you are the custodial parent, you can treat your child under age 13 as a Qualifying Individual even if you cannot claim the child’s exemption. If you are the noncustodial parent, you cannot treat your child under age 13 as a Qualifying Individual, even if you can claim the child’s exemption. If you have questions about whether a particular individual is a Qualifying Individual, contact the Human Resources Department.

**EXAMPLE:** If you must place your four-year-old son in a child care center in order for you to work as a full time employee of the College, or to enable your spouse to seek employment while you remain employed by the College, this child care expense would be eligible for reimbursement. The cost of schooling for kindergarten or higher is not eligible for reimbursement under the Plan, but the cost of care provided before and after school is eligible.

The Plan will not reimburse you for amounts you pay for services performed by your dependent, or a dependent of your spouse, or by your child if the child is under the age of 19. For example, a payment to your 15-year-old daughter for baby-sitting your son is not eligible for reimbursement.

If you elect to receive dependent care reimbursement coverage, you will elect your maximum level of coverage for the Plan Year. The maximum level of coverage is $5,000 ($2,500 in the case of a married Participant who files a separate, rather than joint, federal
tax return for the taxable year), reduced by the amount that your spouse may put into this or another dependent care reimbursement plan. A pro rata portion of your annual election will be used to fund your account from time to time. For example, if you elect $4800 of coverage for the Plan Year, $400 of your Salary Reduction Contributions will be used each month to fund your dependent care reimbursement account. At any point in time during the Plan Year you can claim reimbursement benefits in an amount equal to the remaining balance in your account (the amount of Salary Reduction Contributions used so far during the Plan Year to fund the account, reduced by prior benefit payments from the account, as of the date the claim is approved). Your account for each Plan Year only covers expenses incurred during your Period of Coverage for that Plan Year.

**SPECIAL RULES RELATING TO REIMBURSEMENT BENEFITS**

1. **Forfeitures.** Federal tax laws require that your health care expense reimbursement and dependent care reimbursement benefits for each Plan Year operate on a “use it or lose it” basis. For this reason, if you do not use the entire amount available for reimbursement benefits for a Plan Year, **YOU WILL FORFEIT the unused amount**, and you will have no further claim to it.

   For example, assume you allocate $2,400 during the Plan Year ending August 31, 2011 to your dependent care reimbursement account. During this Period of Coverage, however, you incur only $2,200 of expenses eligible for reimbursement under the Plan. You will forfeit the $200 remaining in your dependent care reimbursement account for that Plan Year after you have been reimbursed for all of your eligible expenses.

2. **The Plan Year and the Period of Coverage.** Your health care reimbursement coverage and dependent care reimbursement account for a particular Plan Year can only be used to provide reimbursement for eligible expenses incurred during your Period of Coverage for that Plan Year.

   *Period of Coverage - Generally the same as the Plan Year. However, if you become a participant after a Plan Year has started, the Period of Coverage consists of your first day of participation and the remainder of the Plan Year. For example, if you become a participant on January 1, 2011, the Period of Coverage for dependent care reimbursement benefits for the Plan Year ending August 31, 2011 is January 1 through August 31, 2011.*

   There are a few exceptions to this general rule:

   - **The Plan has a “grace period” following the end of the Plan Year, during which expenses for health care reimbursements may still be incurred. This “grace period” extends the Period of Coverage to each October 31.**

   - **For all benefits except dependent care reimbursement, if you stop paying for these benefits, your Period of Coverage will end early.** For
example, if you terminate employment or take an unpaid leave of absence, your Period of Coverage will end as of the end of the last month for which you pay for coverage (including any months paid for as continuation coverage).

- In the case of health care reimbursement coverage, the Period of Coverage ends upon termination of employment or when you cease to be an Eligible Employee. In certain circumstances the Period of Coverage can be continued to the end of the Plan Year in which you cease to be an Eligible Employee. (See YOUR RIGHTS TO CONTINUATION COVERAGE)

- With respect to health care reimbursement, the Period of Coverage does not include any portion of the Plan Year for which you do not pay the applicable health care reimbursement contribution.

- With respect to dependent care reimbursement coverage, the Period of Coverage shall extend to the last day of the Plan Year, if your participation ceases due to the termination of employment or if you cease to be an Eligible Employee.

- If you take a “family or medical leave,” you may be able to reinstate your coverage for health/dental insurance and health care reimbursement benefits. This would affect your Period of Coverage for health care reimbursement benefits. (See LEAVES OF ABSENCE AND FAMILY OR MEDICAL LEAVES.)

For example, if you become a participant on January 1, 2011, and have elected to receive health care reimbursement coverage for your first Plan Year ending August 31, 2011, and you are employed for the full year, you can receive reimbursement only for eligible expenses incurred from January 1 through August 31, 2011, which is your Period of Coverage for that Plan Year. Expenses incurred in December 2010, or November 2011, are not eligible for reimbursement under your coverage for that Plan Year.

In the case of health care reimbursement coverage, your Period of Coverage will end as of the end of the last month for which you pay for coverage. For example, if your employment terminates on June 15 and you paid for health care reimbursement coverage through June and elect not to pay for continuation coverage with after-tax dollars (see YOUR RIGHTS TO CONTINUATION COVERAGE), your Period of Coverage would end as of the end of June. As a result, you would not be entitled to reimbursement for expenses incurred in July or August of that year. If you are eligible for and elect to pay for continuation coverage on an after-tax basis, your Period of Coverage would be extended, but not later than the end of the Plan Year in which you terminate. (These results can differ somewhat if you take a family or medical leave, your health care reimbursement coverage terminates, and you later reinstate the coverage. See LEAVES OF ABSENCES AND FAMILY OR MEDICAL LEAVES.)
3. **When is an Expense “Incurred”?** A health care expense or dependent care expense is incurred when the health care or dependent care-giving rise to the expense is provided. The date of billing or payment is irrelevant.

For example, if you visit your dentist on August 15, 2011, are billed for the dental services on September 5, 2011, and pay the bill on September 14, 2011, you will have incurred the expense on August 15, 2011. Consequently, the expense would be eligible for reimbursement under your health care reimbursement coverage for the Plan Year ending August 31, 2011, but not under your coverage for under the Plan Year ending August 31, 2012. Similarly, if you purchase eyeglasses on August 29, 2011 but do not pick them up until September 7, 2011, the expense is eligible for the Plan year ending August 31, 2011.

4. **How Do I Claim Reimbursement Benefits?** If you have elected reimbursement coverage, you may claim reimbursement for eligible health care and/or dependent care expenses that are incurred by October 31. This period includes a 60 day grace period from August 31, the end of the Plan Year. Those expenses must be submitted no later than November 30. You will receive reimbursement via a check from SelectAccount or as a direct deposit into your bank account if you elected direct deposit.

Claims for reimbursement are generally processed by the College’s third party administrator, SelectAccount. If you have elected the “crossover” feature through SelectAccount, your reimbursement claims are automatically forwarded from Blue Cross and Delta Dental for processing. If these procedures apply to your claim, your reimbursement will require no further action on your part.

If you have not elected crossover, you must submit your claims directly. In addition, over the counter medical and eye expenses also must be submitted via claim forms even for participants who have elected crossover. If your claim is not eligible for crossover (for example, if your claim relates to the purchase of eyeglasses), you must deliver a completed claim form to SelectAccount to be reimbursed. You must attach a copy of your bill or receipt or other satisfactory third party documentation of the amount of the expense and the date(s) the expense was incurred (a canceled check or charge slip is not sufficient), and you must certify that each expense is eligible for reimbursement under the Plan, that it has not been previously reimbursed under the Plan, and that it is not reimbursable from any other source (e.g., insurance or your spouse’s Flex Plan). Third party documentation for prescribed over-the-counter medicines includes a copy of the doctor’s prescription for that medicine.

You may obtain claim forms by going to [www.stolaf.edu](http://www.stolaf.edu) - clicking on A-Z - clicking on H - clicking on Human Resources – clicking on Benefits Information – clicking on Forms (under Medical Reimbursement SelectAccount or Dependent Care Reimbursement SelectAccount). Alternatively, you may go directly to [www.selectaccount.com](http://www.selectaccount.com) - Manage Your Account - Member - Products - FSA - Forms and Resources - Medical Expense Reimbursement Account Claim Forms or Dependent Care Expense Reimbursement Account Claim Form.
After your claim is reviewed, processed, and approved, you will receive reimbursement by check or by direct deposit into your bank account.

Nondiscrimination Requirements

Tax laws impose a variety of nondiscrimination requirements and benefits tests that must be met before benefits under the Plan will be nontaxable to all employees. These are generally intended to restrict the amount of nontaxable benefits available to certain employees of the College who are officers, directors, or “highly compensated.” If the College believes that any of these requirements or limits may be violated, it may limit the amount of Salary Reduction Contributions certain participants may allocate to nontaxable benefits, so that the Plan and its benefits will not be discriminatory.

Making a Benefit Election

Prior to the start of your participation in the Plan for a Plan Year, at a time announced by the College, you must complete and return to the College an Election of Benefits form setting out your benefit elections and indicating how much of your Salary Reduction Contributions, if any, you want used to pay your Benefits. The College will advise you in advance of the restrictions, if any, which apply to your elections. If you do not make a benefit election, you will not be able to participate in the Benefits for the Plan Year, unless you have a Status Change or another event occurs that would permit you to make an election change.

Changing Your Benefit Election

After a Plan Year begins you generally cannot change your benefit election or allocation of Salary Reduction Contributions. However, if there is a Status Change you may change your elections. Any such election change must be consistent with the Status Change.

Status Change - A change in circumstances that qualifies as a status change under applicable regulations and is recognized by the College as a “Status Change” under the Plan. These include:

- an event that changes your marital status, including marriage, death, divorce, legal separation or annulment,
- an event that changes your number of dependents, including birth, adoption, placement for adoption or death of a dependent,
- termination or commencement of employment by you, your spouse, or your dependent, which results in a gain or loss of eligibility,
- change in employment status, such as a reduction or increase in your hours of employment or those of your spouse or dependent, including a switch between part-time and full-time, a change in worksite, strike or lockout, which results in a gain or loss of eligibility,

- commencement or return from an unpaid leave of absence or an FMLA leave on the part of you or your spouse,

- an event that causes your dependent to satisfy or cease to satisfy the requirements for coverage under this Plan or an underlying plan, due to attainment of age, student status or any similar circumstance, or in the case of the dependent care reimbursement benefit, your dependent ceases to be a Qualifying Individual,

- change in the place of your residence or that of your spouse or dependent, which affects eligibility for an underlying benefit, such as moving outside of an HMO service area, or

- a change in coverage due to spouse or dependent’s open enrollment.

For health and accident plans, Status Change also includes:

- the exercise of a right under the special enrollment rights of the Health Insurance Portability and Accountability Act ("HIPAA"),

- certain court orders related to health coverage of a dependent or former spouse,

- the entitlement (or loss of entitlement) to Medicare or Medicaid of you, your spouse, or your dependent, or

- the loss of coverage or employer contributions under another group health plan or the exhaustion of COBRA coverage.

Consistency Rule
Any benefit election change must be consistent with the Status Change and permitted under the terms of the underlying plan or policy. For example, if your spouse becomes unemployed, you may stop or reduce the rate of additions to your dependent care reimbursement account. You may not reduce your health care reimbursement coverage to a level lower than the amount of health care reimbursement benefits that you have already claimed for the Plan year.

Timing of Election Changes
Any such change in your election must be made using College forms before or after the Status Change, but not later than 30 days after the date of the Status Change. Such a change will be effective as of the first day of the month after the College receives notification, or, if later, the first day of the month after the Status Change occurs.
**Automatic Changes**
The College reserves the right to automatically initiate changes to your elections where an insignificant change in cost occurs (determined solely by the College) or where the Plan is required to follow a judgment, decree or order that mandates coverage for your dependent.

**Rehires**
If you stop making contributions for benefits during a Plan Year because of a termination of employment and are reemployed within 30 days, you will not be able to make a new benefit election for that Plan Year and your prior election will be automatically reinstated, if permitted under the terms of the underlying plan or policy. If you are reemployed more than 30 days after termination, you may make a new benefit election for the balance of the Plan Year.

**Change in Cost or Coverage – Health Care Reimbursement**
If the College, in its sole discretion, determines that a cost increase is “significant,” you may increase your Salary Reduction Contribution election or revoke your Salary Reduction Contribution election and make a new election for coverage under a similar welfare benefit plan. Likewise, if the College in its sole discretion determines that your coverage is “significantly curtailed,” you may revoke your election and make a new election for coverage under a similar benefit plan. To meet the “significant curtailment” standard, there must be an “overall reduction in coverage” resulting in reduced coverage to participants in general, not just you, your spouse or dependent. If a new option is added or if an option is eliminated, you may make a new election that corresponds to the change. The College will determine when and if these provisions apply and notify you of any resulting election change opportunities.

**Change in Cost or Coverage – Dependent Care Reimbursement**
Dependent care reimbursement elections can also be changed under the Change in Cost or Coverage rules described above. This means that if your dependent care provider changes its rates, you may modify your dependent care account elections to conform to the change. Also, if you change providers and there is a cost difference with the change, you may change your election. (Note: where the dependent care provider is a family member, some restrictions apply.) Under federal law, health care spending account elections are not eligible for modification under the change in cost or coverage rules.

**TAXES**
Subject to applicable nondiscrimination requirements discussed above, the College believes that contributions used to pay for benefits other than the dependent care benefits (see below) will not be subject to federal or Minnesota income taxes or to FICA (Social Security and Medicare) taxes. These contributions and benefit payments will not be reduced by income tax or FICA withholding.

Dependent care benefits you receive from your dependent care reimbursement account during a calendar year generally will not be taxable unless they exceed the lower of (a) $5,000 ($2,500 if you are married but file a separate return for the year), reduced by the amount of any dependent care credit you claim for other expenses (see SPECIAL NOTICE CONCERNING DEPENDENT CARE
EXPENSES below) or (b) your income limitation for that year. If the amount of dependent care benefits exceeds your income limitation, the excess will be taxable. If you are single, your income limitation for a year is your earned income for that year. If you are married, your income limitation is the lower of (a) your earned income for the year, or (b) your spouse’s earned income for the year. If your spouse is a full-time student or is physically or mentally incapable of caring for himself or herself during the year, your spouse will be considered to have earned income of $200 per month if you have one dependent who qualifies for coverage or $400 per month if you have two or more dependents who qualify for coverage.

However, to sustain the nontaxable status of dependent care benefits you receive from the Plan, you will be required to report the amount of those reimbursements and the name, address, and the social security number or employer identification number of the dependent care provider on your federal income tax return.

By each January 31, as part of your W-2, the College will provide you with a statement showing the amount of dependent care reimbursement paid to you during the preceding calendar year so that you can calculate the amount, if any, that was taxable. The College will not withhold income taxes or FICA taxes from dependent care benefit payments.

Illustration of Tax Savings
To illustrate the tax savings offered by the Plan, suppose Terry expects to be paid a gross salary of $26,000 during the year. Also, anticipate that Terry’s spouse will receive gross salary of $40,000 during the year. If Terry and her spouse have 2 children and expect to have $1,800 in dependent care expenses and $900 in employee costs for medical plan coverage and medical expense reimbursement, Terry may, by participating in the Plan, receive benefits from the Plan which allow her to pay the expenses with pre-tax dollars. The difference is illustrated in the following table. The illustration assumes that Terry and her spouse will file “Married Filing Jointly,” they will claim 4 exemptions and take the standard deduction, and the premiums all qualify as pre-tax premiums if paid through the Plan.

<table>
<thead>
<tr>
<th>Without Plan</th>
<th>With Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual earnings</td>
<td>$66,000</td>
</tr>
<tr>
<td>Dependent Care expense/health care expenses/medical plan premiums paid pre-tax through Plan</td>
<td>-0</td>
</tr>
<tr>
<td>Taxable compensation</td>
<td>$66,000</td>
</tr>
<tr>
<td>Estimated Federal Income Taxes (est. 2000 rates)</td>
<td>-7,586</td>
</tr>
<tr>
<td>FICA (Social Security and Medicare) Tax (2000 rate 7.65%)</td>
<td>-5,049</td>
</tr>
<tr>
<td>After-tax compensation</td>
<td>$53,365</td>
</tr>
<tr>
<td>Dependent Care expenses/medical expenses &amp; premiums paid after-tax</td>
<td>-2,700</td>
</tr>
<tr>
<td>Plus child care tax credit</td>
<td>+396</td>
</tr>
<tr>
<td>Spendable income after taxes, dependent care expenses, health care expenses, medical plan premiums</td>
<td>$51,061</td>
</tr>
</tbody>
</table>
Terry’s total gross compensation, considering both gross salary and Plan benefits, will have stayed the same, but her compensation after federal taxes, dependent care expenses, health care expenses, and medical plan premiums will have increased by $567. In this example, Terry is in the 28% tax bracket. A participant in the 15% tax bracket would save less and a participant in a higher tax bracket would save more. These calculations do not include the additional savings that result if you can exclude dependent care expenses, health care expenses and premiums from state income taxes.

The full or partial nontaxability of benefits is the primary benefit of the Plan. However, the exact effect the Plan will have on you will depend on the benefits you elect as well as other factors that affect the amount of income taxes you pay.
SPECIAL NOTICE
CONCERNING MEDICAL CARE AND DEPENDENT CARE EXPENSES

If you receive nontaxable reimbursement from the Plan for health care or dependent care expenses, you may not deduct or take a credit for these expenses on your tax return. IRS Publications 17, 502 and 503 offer further guidance about tax credits. These publications are available on the Internet at www.irs.gov or by calling 800-829-3676.

SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES

Under current law, a tax credit is available for the same type of dependent care expenses that are eligible for reimbursement through the Plan. The amount of the credit depends on the taxpayer’s adjusted gross income and ranges from 20% to 35% of eligible expenses up to a specified limit. For plan years beginning on or after January 1, 2003, the limit is $3,000 of expenses if there is one eligible Dependent and $6,000 of expenses if there are two or more eligible Dependents. You will not be eligible to take the tax credit for any expenses reimbursed through the Plan, and the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent care reimbursements you receive under the Plan.

For example, if you have two children for whom you incur $7,000 of dependent care expenses in 2003 and you have $2,000 reimbursed through the Plan, the maximum amount of your expenses eligible for the tax credit is $4,000. The $2,000 reimbursed from the Plan cannot be considered for the tax credit, reducing the $6,000 (the maximum amount for two or more eligible dependents) to $4,000 ($6,000 less $2,000). This means that even though you incurred $7,000 of dependent care expenses, the total amount subject to a tax benefit is $6,000 -- $2,000 through the Plan and $4,000 through the tax credit. Determining whether taking the credit or reimbursement under the Plan is more beneficial involves complex calculations. Because each individual’s situation is different, the College cannot predict whether or not it would be more beneficial to you to take the tax credit for dependent care expenses or to have your expenses reimbursed under the Plan.

POTENTIAL DISADVANTAGES OF PARTICIPATING

IRS regulations do not allow the College to return unused contributions to you at the end of the Plan Year. For some people, the federal tax credit for dependent care may provide for greater tax savings than the dependent care reimbursement account. Under federal law, an earned income credit is available for individuals with lower incomes. Participation in the Plan may affect your eligibility for the earned income credit and/or the amount of the credit. Also, participation in the Plan lowers your income which may mean that the amount of social security benefits and other government-provided, pay-related benefits for which you later may be eligible may be reduced.
Your use of Salary Reduction Contributions for nontaxable benefits from the Plan should not affect your benefits from other pay-related benefit plans. These are based on your gross pay without regard to any Salary Reduction Contributions under this Plan.

**TERMINATION OF EMPLOYMENT**

If your employment terminates, your Salary Reduction Contributions will cease. You will be entitled to continue to receive reimbursement of eligible dependent care expenses incurred during the remainder of the Plan Year in which your employment terminated to the extent of the amount remaining in your dependent care account for that Plan Year at the time your employment terminated. You may be able to elect to continue certain coverages by making after-tax contributions. (See CONTINUATION COVERAGE.) If you stop making payments toward that coverage, the coverage will cease. In the case of health care reimbursement coverage, see the discussion of “The Plan Year And The Period Of Coverage” in SPECIAL RULES RELATING TO REIMBURSEMENT BENEFITS.

**LEAVES OF ABSENCE AND FAMILY OR MEDICAL LEAVES**

If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993 (“FMLA”), the way in which you may participate in the Plan will depend on whether or not you continue to receive compensation from the College. If during a leave you continue to be paid by the College, your benefit election will remain in effect and the College will continue to withhold Salary Reduction Contributions. If you are not being paid by the College, your participation in the Plan will be treated in the same way as if you had terminated employment. Thus, you cannot make contributions to your dependent care reimbursement account, but you can continue to submit claims through the end of the Plan Year or, if earlier, until your account is depleted. You can pay for your medical insurance and any health care expense reimbursement benefits on an after-tax basis. When you return to work your prior benefit election will be reinstated.

If you take a leave of absence that is a family or medical leave under FMLA, you should contact the Human Resources Department to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave, you may continue to participate in the Plan provided you continue to pay for your benefits. You can elect to pay for your benefits in one of the following three ways:

1. You can pay for your benefits on a pre-tax basis by allowing us to deduct your required contributions from your paychecks before the leave. (Due to certain tax law restrictions, you can only prepay on a pre-tax basis through the end of a Plan Year.)

2. You can pay for your benefits for the duration of the leave on an after-tax basis by a single lump-sum payment at the beginning of the leave.
You can pay for your benefits on an after-tax basis during the leave by sending your payment to the College on or before the 1st day of each month.

If you receive taxable pay from the College during your leave, you can pay for your benefits on a pre-tax basis through Salary Reduction Contributions from that pay. If you fail to make arrangements to pay for your benefits during a family or medical leave, the College reserves the right to recover the cost of such coverage from you at the end of the family or medical leave to the fullest extent authorized by FMLA.

Please contact the Human Resources Department as soon as you know you will be taking a family or medical leave.

**QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

In certain circumstances, a child of a participant in the Plan may be able to enroll in a medical plan sponsored by the College (including the health care expense reimbursement portion of this Plan) by filing a “Qualified Medical Child Support Order” (“QMCSO”) with the College. A QMCSO may only be filed with respect to a child of a Participant in the Plan. If you are interested in more information relating to QMCSO and the procedures for filing them with the Plan, please contact the Human Resources Department.

**YOUR RIGHTS TO CONTINUATION COVERAGE**

Under a federal law that is commonly known as COBRA (Public Law 99-272, Title X), most employers sponsoring “group health plans” are required to offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) in certain instances where coverage under the plan would otherwise end. The health care reimbursement portion of the Plan, the Comprehensive Major Medical Plan portion, the Dental Plan portion and the Employee Assistance Plan (“EAP”) qualify as “group health coverage” for purposes of COBRA (each a “COBRA plan”). This notice generally explains COBRA continuation coverage, when it becomes available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. Both you and your spouse should take the time to read this notice carefully.

**If You Have Questions**

Questions concerning the Plan or your COBRA continuation rights should be addressed to the Plan Administrator, using the contact information at the end of this Summary Plan Description. The Plan Administrator is St. Olaf College. The Plan Administrator is responsible for administering COBRA continuation coverage. The party responsible for administering COBRA continuation coverage, or that party’s address and telephone number, may change from time to time. For the most recent information, check the Plan’s most recent Summary Plan Description (if you do not have a copy, you may request one from the Plan Administrator.)
Continuation coverage under the health care reimbursement portion of the Plan may not be available in certain circumstances. Please contact the Human Resources Department for further information.

If you have questions about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA website.

What is 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. After a qualifying event, 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 or former spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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 the College, and that bankruptcy results in the loss of coverage of any retired employee covered under a COBRA 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 COBRA plan.

If you are an employee of the College covered by a COBRA plan you have a right to choose this continuation coverage if you lose your group health coverage under the COBRA plan because of either of the following reasons:

1. A reduction in your hours of employment; or,
2. The termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by a COBRA plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the COBRA plan for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
(3) Your spouse becomes entitled to Medicare (Part A, Part B, or both); or

(4) Divorce or legal separation from your spouse. If an employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the divorce or legal separation and can establish that the employee cancelled the coverage earlier in anticipation of the divorce or legal separation, then the COBRA coverage may be available for the period after the divorce or legal separation.

In the case of an employee’s dependent child who is covered by a COBRA plan (including a child born to or placed for adoption with a covered employee during the COBRA continuation period and alternate recipients under QMCSOs), he or she has the right to continuation coverage if group health coverage under the COBRA plan is lost for any of the following reasons:

(1) The death of a parent-employee;

(2) The termination of a parent-employee’s employment (for reasons other than gross misconduct) or reduction in a parent-employee’s hours of employment with the College;

(3) Parents’ divorce or legal separation;

(4) A parent becomes eligible for Medicare (Part A, Part B, or both); or

(5) The dependent ceases to be eligible under the Plan as a “dependent child.”

When is COBRA Coverage Available?

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

IMPORTANT: You Must Give Notice of Some Qualifying 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 later of the qualifying event or the loss of coverage using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator, the employee will lose the right to continuation coverage.
Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

How is COBRA Coverage Provided?

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

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 the reduction of the employee’s hours of employment due to a military leave that qualifies under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), COBRA continuation coverage lasts for up to 24 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 three ways in which this 18-month period of COBRA continuation coverage could 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 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. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan requires you to follow the procedures specified above, entitled “Notice Procedures.” In addition, your notice must include the name of the disabled qualified beneficiary, the date that the qualified beneficiary became disabled, and the date that the Social Security Administration made its determination. Your notice must also include a copy of the Social Security Administration’s determination. If these procedures are not followed, or if the
notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is given properly to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if that event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying 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. The Plan requires you to follow these procedures specified above, entitled “Notice Procedures.” Your notice must also name the second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required 60-day period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.

Medicare extension for spouse and dependent children
If a qualifying event that is the employee’s termination of employment or reduction of hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, then the maximum coverage period for the spouse and dependent children will end 36 months after the date the employee became entitled to Medicare (but the covered employee’s maximum coverage period will be 18 months). For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Birth or Adoption of Child while on COBRA Continuation Coverage
If, while you are a Qualified Beneficiary receiving continuation coverage under COBRA, a child is born to you or you adopt a child, you must notify the Plan Administrator in writing within 30 days of the birth or adoption to add that child to your continuation coverage. The Plan requires you to follow these procedures specified above, entitled “Notice Procedures.” IF YOU FAIL TO PROPERLY NOTIFY THE PLAN ADMINISTRATOR, YOU MAY NOT BE ABLE TO ADD THE CHILD TO YOUR CONTINUATION COVERAGE.

Notice Procedures
Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. To provide notice to the Plan Administrator you must mail your notice to the Human Resources Department at this address:

St. Olaf College  
1520 St. Olaf Avenue  
Northfield, MN 55057

(For the most recent information, check the Plan’s most recent Summary Plan Description. If you do not have a copy, you may request one from the Plan Administrator.) Summary Plan Descriptions for all of the College’s Plans are also available at the College website. You may obtain Summary Plan Descriptions by going to www.stolaf.edu - clicking on A-Z - clicking on H - clicking on Human Resources – clicking on Summary Plan Descriptions under Benefits.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan, the name and address of the employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

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. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

MILITARY LEAVE OF ABSENCE

If you take a military leave of absence you may have a right to have your coverage continued under group health plans, including the health care expense reimbursement portion of this Plan. Upon your return from a military leave of absence you may have a right to reinstate your coverage without any waiting periods.

PLAN AMENDMENT OR TERMINATION

The College reserves the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended, your rights accrued prior to the amendment will not be affected. Your rights for periods after the amendment will depend on the amendment.

If the Plan is terminated, your Salary Reduction Contributions will cease. If the Plan is terminated, the College expects that you would be able to continue receiving reimbursements of eligible dependent care expenses on the same basis as if your employment had terminated.
PLAN ADMINISTRATION

The Plan is a sponsor-administered plan, and the Plan Administrator is the College, whose address, business telephone number, and Employer Identification Number are:

St. Olaf College
Northfield, MN 55057
Telephone: (507) 646-2222
Employer Identification Number: 41-0693979

The College (and persons to whom it has delegated powers, to the extent of such delegations) has total and complete authority to (1) determine conclusively for all parties all questions arising in the administration of the Plan, (2) interpret and construe the terms of the Plan, and (3) determine all questions of eligibility and status of Employees, participants, and beneficiaries under the Plan and their respective interests. Such determinations are binding on all persons, subject to the claims procedures under the Plan.

IF YOU NEED MORE INFORMATION

This document is just a summary of the actual terms of the Plan. You may examine a copy of the actual Plan at the Human Resources Department of St. Olaf College at any time during regular working hours. You may also obtain a copy of the Plan by furnishing a written request for a copy to the Human Resources Department. There may be a charge for the expense of copying the Plan document. Since this document is only considered to be a summary, in case of any inconsistencies between this summary and the Plan, the Plan shall control.

Also, certain information concerning the Plan is filed with the Treasury Department and the Department of Labor. Should you wish to correspond with either agency about this Plan, you must refer to Employer Identification Number 41-0693979 and Plan Number 509.

The Treasurer has been designated as agent for purpose of service of legal process. Also, the Plan Administrator may be served legal process. The address of the agent for service of process is the address of the Plan Administrator as shown above.

CLAIMS FOR BENEFITS

Claims for benefits under the medical and dental plans are described in the St. Olaf College Comprehensive Major Medical Plan Summary Plan Description and the St. Olaf College Dental Plan Summary Plan Description. Unless otherwise provided in this summary plan description, the summary plan description listed above or other documents governing a particular benefit plan, the following procedure will apply to claims for benefits under the Plan.

You or your beneficiary may file a written claim with the College requesting a benefit under the Plan or objecting to the determination of your benefit.
You must file a claim on the form or forms available for that purpose in order for a claim to be valid. Forms are available from the sources referenced in this booklet, or you may obtain the form you need from the Plan Administrator.

The Plan Administrator will notify you in writing within a reasonable time not longer than 30 days after your written application for benefits of your eligibility or non-eligibility for benefits under the Plan. If the Plan Administrator needs additional time to evaluate your claim, it will notify you within the first 30 days how much additional time is needed, but not more than another 15 days. If the Plan Administrator requests additional information, you will have 45 days to provide that information. The review period will be suspended until the specified information is received. If the Plan Administrator determines that you are not eligible for benefits or full benefits, the notice will tell you:

(1) the specific reasons for the denial,
(2) the specific provision of the Plan on which denial is based,
(3) a description of any additional information or material necessary for you to complete your claim and an explanation of why such information or material is necessary, and
(4) an explanation of the Plan’s claim review procedure, including the time limits applicable to the review procedure and your right to bring a civil action under ERISA following an adverse benefit determination on review.

If the Plan Administrator determines that you are not eligible for benefits, or if you believe that you are entitled to greater or different benefits, you will have the opportunity to have your claim reviewed by the Plan Administrator by filing a petition for review with the Plan Administrator within 180 days after you receive the notice issued by the Plan Administrator. If you do not request a review within that time period you will lose the right to appeal the determination. Your petition should state the specific reasons why you believe you are entitled to benefits, or greater or different benefits. You have the right to obtain from the College, on request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. You should make sure that your request for review includes all the information relevant to your claim.

Within 60 days after the Plan Administrator receives the petition, the Plan Administrator will give you a written decision of its review, either in paper or electronic form. The Plan Administrator may hold a hearing for the review of your claim if you request and it decides such a hearing is necessary. The Plan Administrator’s decision will state:

(1) the specific reason or reasons for the adverse determination,
(2) the specific Plan provisions and/or rule on which the benefit determination is based,
(3) that you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(4) that you are entitled to bring an action under ERISA, and

(5) that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

You may choose to have a representative represent you in the claims procedure. If you do, the College may require proof that the individual is authorized to act on your behalf. Note that you must follow this claims procedure if you have a claim, and the failure to do so will prevent you from challenging an adverse decision in court.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

If you want more information about the Plan’s privacy practices, have questions or concerns, or believe that the Plan may have violated your privacy rights, please contact the Plan using the Administrative Information at the end of this Summary Plan Description.

You may also submit a written complaint to the U.S. Department of Health and Human Services. The Plan will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

The Plan supports your right to protect the privacy of your medical information. The Plan will not retaliate in any way if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations all documents governing the plan, including insurance contracts, 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 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 plan administrator may make a reasonable charge 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 group health plan coverage for yourself, spouse or dependents if there is a loss of coverage under a group health portion of the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Continuation of Coverage section of this summary plan description on the rules governing your group health continuation of coverage rights.

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 ERISA benefit plans. The people who operate such plans, called “fiduciaries” of the plan, have a duty to administer the plan prudently and in the interests of 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 benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA 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 a copy of plan documents or the latest annual report 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 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 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, in certain circumstances, the court may order you to pay these costs and fees, for example, if it finds that 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 Benefit Security 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 Employee Benefit Security Administration.
This document is just a summary of the actual terms of the Plan. You may examine a copy of the actual Plan at the Human Resources Department at any time during regular working hours. You may also obtain a copy of the Plan by furnishing a written request for a copy to St. Olaf College, at the address below. There may be a charge for the expense of copying the Plan document. Since this document is only considered to be a summary, in case of any inconsistencies between this summary and the Plan, the Plan shall control.

Also, certain information concerning the Plan is filed with the Treasury Department and the Department of Labor. Should you wish to correspond with either agency about this Plan, you must refer to Employer Identification Number and Plan Number.

<table>
<thead>
<tr>
<th>Name of the Plan:</th>
<th>St. Olaf College Flexible Benefits Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer, Plan Sponsor and Plan Administrator:</td>
<td>St. Olaf College</td>
</tr>
<tr>
<td></td>
<td>Northfield, MN  55057</td>
</tr>
<tr>
<td></td>
<td>507-786-3068</td>
</tr>
<tr>
<td>Employer I.D. Number:</td>
<td>41-0693979</td>
</tr>
<tr>
<td>Plan Numbers:</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Major Medical Benefits Plan and Dental Benefit Plan</td>
<td>504  These plan numbers are listed for your information to identify the plans offered by St. Olaf College.</td>
</tr>
<tr>
<td>Medical Care Expense Reimbursement Plan</td>
<td>508</td>
</tr>
<tr>
<td>The Dependent Care Expense Reimbursement Plan does not have a number as it is not a benefit covered under ERISA, and no filings are required</td>
<td></td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>This Plan is commonly known as a “Cafeteria Plan,” and it includes a Premium Conversion Plan, a Medical Care Expense Reimbursement Plan, and a Dependent Care Expense Reimbursement Plan.</td>
</tr>
<tr>
<td>Type of Funding:</td>
<td>This Plan is funded by employee contributions made through salary reduction elections under the Plan. No health insurance issuer is responsible for the financing or administration of the Plan.</td>
</tr>
<tr>
<td>Type of Administration:</td>
<td>Plan Sponsor maintains records.</td>
</tr>
<tr>
<td>Plan Expenses:</td>
<td>Forfeitures will be used to offset Plan administration expenses. Other costs will be paid by the College.</td>
</tr>
<tr>
<td>Agent for Service of Legal Process:</td>
<td>The Treasurer or the Plan Administrator – at the address listed above.</td>
</tr>
</tbody>
</table>
Requests for Information:  If you have any questions regarding your benefits, or wish to examine the Plan, please contact the St. Olaf College Human Resources Department at the address and telephone number listed above. All requests, appeals, elections and other communications should be in writing and should be hand delivered or sent by certified mail.

Plan Year:  September 1 through August 31.

The College (and persons to whom it has delegated powers, to the extent of such delegations) has total and complete authority to (1) determine conclusively for all parties all questions arising in the administration of the Plan, (2) interpret and construe the terms of the Plan, and (3) determine all questions of eligibility and status of Employees, participants, and beneficiaries under the Plan and their respective interests. Such determinations are binding on all persons, subject to the claims procedures under the Plan.