

Vermont Law School Flexible Spending Plan
Summary Plan Description

Revised Effective January 1, 2004

TABLE OF CONTENTS

I ELIGIBILITY

1. When Can I Become a Participant in the Plan?..... 1
2. What Are the Eligibility Requirements for Our Plan? 1
3. When Is My Entry Date? 1
4. Are There Any Employees Who Are Not Eligible?..... 1
5. What Must I Do to Enroll in the Plan?..... 2

II OPERATION

1. How Does This Plan Operate?..... 2

III CONTRIBUTIONS

1. How Much of My Pay May the Employer Redirect?..... 2
2. What Happens to Contributions Made to the Plan?..... 2
3. When Must I Decide Which Accounts I Want to Use? 2
4. When Is the Election Period for Our Plan?..... 3
5. May I Change My Elections During the Plan Year?..... 3
6. May I Make New Elections in Future Plan Years?..... 4

IV BENEFITS

1. What Benefits Are Available?..... 4

V BENEFIT PAYMENTS

1. When Will I Receive Payments From My Accounts?..... 6
2. What Happens If I Don't Spend All Plan Contributions? 6
3. Family and Medical Leave Act (FMLA)..... 6
4. Uniformed Services Employment and Reemployment Rights Act 7
5. What Happens If I Terminate Employment?..... 7
6. Will My Social Security Benefits Be Affected?..... 9

VI HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Highly Compensated Employees? 9

VII
PLAN ACCOUNTING

1. Periodic Statements..... 9

VIII
GENERAL INFORMATION ABOUT OUR PLAN

1. General Plan Information 9
2. Employer Information..... 10
3. Plan Administrator Information..... 10
4. Service of Legal Process 10
5. Type of Administration 10
6. Claims Submission 11

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA..... 11
2. Claims Process..... 12

X
SUMMARY

VERMONT LAW SCHOOL FLEXIBLE SPENDING PLAN

INTRODUCTION

We have amended the "flexible benefits plan" that we previously established for you and other eligible employees. Under this program, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this summary plan description. We will also tell you about other important information concerning the amended Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

One of the most important features of our Plan is that the benefits being offered are generally ones that you are already paying for, but normally with money that has first been subject to income and Social Security taxes. Under our Plan, these same expenses will be paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

Read this summary plan description carefully so that you understand the provisions of our amended Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the Plan document will control. Also, if there is a conflict between an insurance contract and either the plan document or this summary plan description, the insurance contract will control.

I ELIGIBILITY

1. When Can I Become a Participant in the Plan?

Before you become a member or a "Participant" in the Plan, there are certain rules which you must satisfy. First, you must meet the "eligibility requirements." After that, the next step is to actually join the Plan on the "entry date" that we have established for all employees. You will also be required to complete certain application forms before you can enroll in the Health Care Reimbursement Plan or Dependent Care Assistance Account.

2. What Are the Eligibility Requirements for Our Plan?

You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When Is My Entry Date?

You can join the Plan on the same day you can enter our group medical plan.

4. Are There Any Employees Who Are Not Eligible?

Yes, there are certain employees who are not eligible to join the Plan. They are:

-- Employees who are not eligible to receive medical benefits under our group medical plan.

5. What Must I Do to Enroll in the Plan?

Before you can join the Plan, you must complete an application to participate in the Plan. The application includes your personal choices for each of the benefits which are being offered under the Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

However, if you are already covered under any of the insured benefits, you will automatically participate in this Plan to the extent of your premiums unless during the "election period" you elect not to participate in this Plan.

II OPERATION

1. How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the Plan. These amounts will be placed in special funds or accounts which must be set up for you in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

III CONTRIBUTIONS

1. How Much of My Pay May the Employer Redirect?

Each year, for the insured benefits provided under this Plan we will automatically contribute on your behalf enough of your compensation to pay for the insurance coverage provided. In addition, you may elect to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year. However, you may not have us contribute more than 100% of your compensation.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins, you will select the non-insured benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

3. When Must I Decide Which Accounts I Want to Use?

You are required by Federal law to decide before the Plan Year begins, during the "election period." You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

If you are already covered by any of the insured benefits offered by this Plan, you will automatically become a Participant to the extent of the premiums for such insurance unless you elect, during the "election period," not to participate in the Plan.

4. When Is the "Election Period" for Our Plan?

Your election period will start on the date you first meet the "eligibility requirements" and end 30 days after your "entry date." (You should review Section I on Eligibility to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period begins 75 days and ends 30 days prior to the beginning of each Plan Year. (See the Article entitled "General Information About Our Plan" for the definition of Plan Year.)

5. May I Change My Elections During the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent.

In addition, if you are participating in the Dependent Care Assistance Program, then there is a "change in status" if your dependent no longer meets the qualifications to be eligible for dependent care.

There are detailed rules on when a change in election is deemed to be consistent with a "change in status." In addition, there are laws that give you rights to change accident and health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Administrator.

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then we will automatically increase or decrease, as the case may be, your salary redirection election. If the cost increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage, or revoke your election entirely.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on a prospective basis coverage under another plan with similar coverage. In addition, if we add a new coverage option or eliminate an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant, you may elect to join the Plan. There are also certain

situations when you may be able to change your elections on account of a change under the plan of your spouse's, former spouse's or dependent's employer.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement Plan, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Assistance Program if the cost change is imposed by a dependent care provider who is your relative.

6. May I Make New Elections in Future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the "election period" before a new Plan Year begins, you will not be considered a Participant for the non-insured benefit options under the Plan for the upcoming Plan Year.

**IV
BENEFITS**

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Care Reimbursement Plan:

The Health Care Reimbursement Plan enables you to pay for expenses which are not covered by our insured medical plan or privately held insurance policies and save taxes at the same time. The account allows you to be reimbursed by the Employer for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify are those allowed under Sections 105 and 213(d) of the Internal Revenue Code. A list of covered expenses is available from the Administrator. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses.

The most that you can contribute to your Health Care Reimbursement Plan each Plan Year is an amount that will be announced by your Employer prior to the beginning of each Plan Year. In order to be reimbursed for a health care expense, you must submit to the Administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month.

Dependent Care Assistance Account:

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses."

Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws.
- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An "Individual" who provides care inside or outside your home. The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents). Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Ask your tax adviser which is better for you.

Premium Expense Account:

A Premium Expense Account allows you to use tax-free dollars to pay for certain premium expenses under various insurance programs that we offer you. These premium expenses include:

- Health care premiums under our insured group medical plan.
- Health care premiums under privately held insurance policies.
- Dental insurance premiums.

Under our Plan, we will establish sub-accounts for you for each different type of insurance coverage that is available. Also, certain limits on the amount of coverage may apply.

The Administrator may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts providing benefits described above. We will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance terminates.

Any benefits to be provided by insurance will be provided only after (1) you have provided the Administrator the necessary information to apply for insurance, and (2) the insurance is in effect for you.

"Privately held insurance policies" do not include coverage obtained through a spouse's employment. Cost of these policies will only be reimbursed on adequate proof of coverage.

V BENEFIT PAYMENTS

1. **When Will I Receive Payments From My Accounts?**

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. Requests for payment of insured benefits should be made directly to the insurer. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the Account to cover your request.

2. **What Happens If I Don't Spend All Plan Contributions?**

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than sixty-two (62) days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. **Family and Medical Leave Act (FMLA)**

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance and the Health Care Reimbursement Plan. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Reimbursement Plan, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference- from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the Health Care Reimbursement Plan are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Reimbursement Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended health care coverage. If you may be affected by this law, ask your Administrator for further details.

5. What Happens If I Terminate Employment?

If you leave our employ during the Plan Year, your right to benefits will be determined in the following manner:

- You will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.
- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your dependent care account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit all claims within sixty (60) days of termination of employment.
- You may elect to continue your participation in the Health Care Reimbursement Plan for the remainder of the Plan Year.
- If you elect to continue your participation in the Health Care Reimbursement Plan, you must continue to make any required contributions to the Plan.
- If you elect not to continue participation in the Health Care Reimbursement Plan, participation will cease and no further salary redirection contributions will be contributed on your behalf.
- If your participation in the Health Care Reimbursement Plan ceases, you will be able to submit claims for health care expenses incurred prior to your date of termination. You must submit all claims within sixty (60) days of termination of employment.

Under Federal law, if you, your spouse, and/or your covered dependents ("qualified beneficiaries") lose coverage under this Plan, then you, your spouse, and/or your covered dependents may be entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if we (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period that could be extended for a second eighteen (18) month period, not to exceed thirty-six (36) months for any of the other reasons given in (b) and (c) below, if these events happen while a qualified beneficiary is already on COBRA continuation coverage. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an employee or otherwise, provided the other employer's health plan does not

contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of our health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

(a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment (other than for reasons of gross misconduct) or reduction in hours, you may continue the health plan coverage provided under this Plan. However, this will not be a tax-deductible expense to you, absent unusual circumstances. Your spouse or covered dependents may also continue health plan coverage for these reasons.

(b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent-employee; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a "dependent child" under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is our responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy (if it results in a loss of coverage), or Medicare eligibility (1) within thirty (30) days of any of these events or (2) within thirty (30) days following the date coverage ends.

You can elect to continue your participation in the Health Care Reimbursement Plan for the remainder of the Plan Year, subject to the following conditions. You may only continue to participate in the Health Care Reimbursement Plan if you have contributed more money than you have taken out in claims. For example, if you elected to contribute an annual amount of \$500 and, at the time you terminate employment, you have contributed \$300 but only claimed \$150, you may elect to continue coverage under the Health Care Reimbursement Plan. If you elect to continue coverage, then you would be able to continue to receive your health care reimbursements up to the \$500. However, you must continue to pay for the coverage, just as the money has been taken out of your paycheck, but on an after-tax basis. The Plan can also charge you an extra amount to provide this benefit. When you terminate employment the Administrator will provide you with a notice regarding your right to continue coverage.

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI HIGHLY COMPENSATED AND KEY EMPLOYEES

1. Do Limitations Apply to Highly Compensated Employees?

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid. You will be notified by the Administrator each Plan Year whether you are a "highly compensated employee" or a "key employee."

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Federal tax laws state that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under our Plan.

Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

VII PLAN ACCOUNTING

1. Periodic Statements

The Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information which you may need to know about the Plan.

1. General Plan Information

Vermont Law School Flexible Spending Plan is the name of the Plan.

Your Employer has assigned Plan Number 502 to your Plan.

The provisions of your amended Plan become effective on January 1, 2004. Your Plan was originally effective on August 1, 1993.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on July 1 and ends on June 30.

2. Employer Information

Your Employer's name, address, and identification number are:

Vermont Law School
P.O. Box 96
South Royalton, Vermont 05068
23-7251952

3. Plan Administrator Information

The name, address and business telephone number of your Plan's Administrator are:

Vermont Law School
P.O. Box 96
South Royalton, Vermont 05068
(802) 763-8303

The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. You may contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Vermont Law School
P.O. Box 96
South Royalton, Vermont 05068

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Future Planning Associates, Inc.
600 Blair Park Road, Suite 331; P.O. Box 905
Williston, VT 05495-0905

IX ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA

Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

(a) examine, without charge, at the Administrator's office, all Plan documents, 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.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) continue health coverage for a Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) review this summary plan description and the documents governing the plan on the rules governing COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan Participants.

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 or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

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.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA) or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. Claims Process

You should submit reimbursement claims during the Plan Year, but in no event later than sixty-two (62) days after the end of a Plan Year. However, if you terminate employment during the Plan Year, you must submit your claims within ninety (90) days after your termination of employment. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If we fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding.

In the case of a claim for medical expenses under the Health Care Reimbursement Plan, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- (1) The specific reason or reasons for the denial.
- (2) Reference to the specific Plan provisions on which the denial was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502 of ERISA following a denial on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the claim determination;

- (2) was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

X SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our flexible benefits plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the Administrator.

Vermont Law School Flexible Spending Plan

Summary Plan Description Material Modifications

I

INTRODUCTION

Your Employer has amended the Vermont Law School Flexible Spending Plan as of the first day of the plan year beginning after 2004 for compliance with recent changes in the tax law.

This is merely a summary of the most important changes to the Plan. If you have any questions, contact your Plan's Administrator. A copy of the Plan, including this amendment, is available for your inspection. If there is any discrepancy between the terms of the Plan or the amendment itself and this summary of material modifications, the provisions of the Plan, as amended, will control.

II

SUMMARY OF CHANGES

Dependent Care Assistance Plan:

The Dependent Care Assistance Plan has been amended to reflect changes required by a new law called the Working Families Tax Relief Act (WFTRA). In general, WFTRA removed the requirement that you maintain the household (i.e., provide over one-half the costs of maintaining the household in which you live) in order to be able to claim dependent care expenses for your dependent. WFTRA also changed who can be a "qualifying individual" for dependent care expenses. One type of "qualifying individual" is an individual who is under age 13 and who can be claimed as an exemption for income tax purposes. Under the new law, the ability to claim a child as an exemption (and for this Dependent Care Assistance Program) is based on residency - whether the child lives with you. Prior to the change, it was based on whether over one-half of the support was provided to the child.