THE STARPOINT CENTRAL SCHOOL DISTRICT
HEALTH REIMBURSEMENT ACCOUNT PLAN

FOR RETIRED NON-TEACHER EMPLOYEES

PLAN SUMMARY

The Starpoint Central School District maintains the Starpoint Central School District Health Reimbursement Account Plan for Retired Non-Teacher Employees. The terms of the Plan are contained in a lengthy, legally worded document. This Plan Summary is intended to acquaint you with the provisions of the Plan that apply to you by summarizing them in language that is easier to understand.

The format for the Summary is a series of questions and answers that cover such key areas as: when you become eligible; what benefits you may receive; and how your benefits are paid for. The Summary is merely intended to describe the Plan in a condensed fashion, not to change it or to add to it. Should the Plan and Summary be inconsistent in any way, the provisions of the Plan will overrule the Summary.

IDENTIFYING INFORMATION

1. Plan Name:

   Starpoint Central School District Health Reimbursement Account Plan for Retired Non-Teacher Employees

2. Employer/Plan Administrator:

   Starpoint Central School District
   4363 Mapleton Road
   Lockport, NY 14094
   716 210-2347

3. Claims Administrator:

   The Plan Administrator has retained P&A Administrative Services, Inc. to assist in Plan administration.

   You may submit your claims online at P&A's website, www.padmin.com, by logging into your P&A Account or by using your smartphone.

   Or you may mail your claims to P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202 or fax them to 716 855-7105.

4. Plan Year-End:

   June 30

THE HEALTH REIMBURSEMENT ACCOUNT PLAN
OVERVIEW

The Plan is intended to reimburse you for some of your uninsured, out-of-pocket costs for health care. The following is a list of some of the more commonly asked questions regarding your Plan.

EFFECTIVE DATE AND PLAN YEAR

WHAT IS THE EFFECTIVE DATE OF THE PLAN?

The Plan started on July 1, 2016.

WHAT IS THE PLAN YEAR?

"Plan Year" refers to the accounting period that is used for purposes of maintaining the Plan's records, which is the 12-month period beginning on July 1 and ending on the following June 30.

ELIGIBILITY AND PARTICIPATION

WHEN AM I ELIGIBLE FOR PLAN PARTICIPATION?

You become eligible for this Plan when you cease to be eligible for the Employer's health reimbursement account plan for active non-teacher employees if you had money credited to your HRA Account when your eligibility for that other plan ceased.

PLAN CONTRIBUTIONS

WHO PAYS FOR THE COST OF PLAN BENEFITS?

All benefits under the Plan are paid by the Employer.

WHO PAYS FOR THE COST OF PLAN ADMINISTRATION?

The Claims Administrator's fees for the administration of your Account will be debited from your Account on a monthly basis.

PLAN BENEFITS

WHAT BENEFITS MAY I RECEIVE UNDER THIS PLAN?

The purpose of the Plan is to help you pay for certain medical expenses that are not covered by health insurance or any other health plan. To qualify for payment, an expense must be considered to be for "medical care" as that term is defined in the Internal Revenue Code. This includes hospital bills, doctor, dental or vision care bills, prescription medicines and over-the-counter medicines. However, medicines other than insulin purchased without a prescription are not covered.

Medicare premiums and other health plan premiums also are eligible for reimbursement.

When you first become a Participant, the Employer will establish an HRA Account in your name and will credit your Account with a certain number of Benefit Dollars. The amount of Benefit Dollars will equal the amount that was credited to your Account under the Employer's health reimbursement account plan for active non-teacher employees after you lost eligibility for that plan and your remaining eligible claims under that plan were reimbursed.

The same eligible expenses when incurred for the medical care of your Spouse and Dependents, if any, also are eligible for reimbursement.

As you have eligible expenses, you can apply to the Plan for reimbursement of those expenses from the Benefit Dollars in your HRA Account. The amount of reimbursement that you may receive when you submit a claim will be limited to the number of Benefit Dollars that are credited to your HRA Account at that time.

Understand that your "Account" exists for record-keeping purposes only and does not involve any actual segregation of funds for your benefit.

WHO IS A SPOUSE AND WHO IS A DEPENDENT?

Under the Plan, only the expenses of a Participant, a Participant's Spouse or a Participant's Dependent are eligible for reimbursement.

Spouses

A person will be considered the Spouse of a Participant if the Spouse and Participant are married for purposes of federal tax law. Under federal tax law, a couple will be treated as married if they were married in a state where their marriage was legal under the law of that state at the time it occurred, irrespective of whether they continue to reside in that state or in another state where same-sex marriage is legal.

Relatives as Dependents

A Participant's relative will be considered to be his or her Dependent if the Participant provided over half of the relative's financial support for the calendar year. If the relative is a child, grandchild, brother, sister, niece or nephew of the Participant who is under age 19 (age 24 in the case of a full-time student), it is not necessary for the Participant to have provided over half of the relative's support if the relative lived with the Participant for more than half of the calendar year and the relative did not provide more than one-half of his or her own support.

A special rule applies to the reimbursement of the health expenses of children of divorced parents. The child of divorced parents or legally separated parents is considered to be a Dependent of both parents if both parents together provide more than 50% of the child's support and have custody of the child for more than half the year.

For purposes of this Plan, "Dependent" also includes any child of a Participant whose 27th birthday will not have occurred by the last day of the current calendar year, irrespective of whether the child satisfies any of the financial support or residency requirements referred to above in this section of the.

Non-Relatives as Dependents

To qualify as a Dependent, a person who is not related to a Participant must:

1. receive over 50% of his or her financial support from the Participant for the calendar year;

2. have the same principal residence as the Participant for the entire calendar year; and

3. be a member of the Participant's household (which is not possible if their living together violates the law of the state where they live).

BENEFIT CLAIMS

You obtain reimbursement for an expense by submitting a claim form and documentation from the provider of the services you received (e.g., a receipted bill, an unpaid bill, or a signed affidavit) stating the nature, date and amount of the expense. Your claims should be submitted directly to the Claims Administrator. After receiving your claim, the Claims Administrator will determine if the expense qualifies for reimbursement and will pay any benefits due you under the Plan.

If your claim arises while you are receiving COBRA Continuation Coverage, your premium payments must be up-to-date (subject to a thirty-day grace period for late payment) to receive benefits.

WHAT ARE MY RIGHTS IF MY CLAIM FOR BENEFITS IS DENIED?

When a Claim is Denied

You will be notified in writing by the Claims Administrator if a claim that you submitted has been denied. As a general rule, you will receive notification of a claim denial within 30 days of the date you submitted your claim. However, the 30-day period may be extended for an additional 15 days due to circumstances beyond the Claims Administrator's control. This would be the case if, for example, you did not include enough information about a particular claim for the Claims Administrator to either allow or deny the claim.

The Claims Administrator will provide you with written notice if it becomes necessary to extend the 30-day period with regard to any claim that you file. The written notice will tell you the reason for the extension and when the Claims Administrator expects to make its decision. If the reason for the extension is that your claim was incomplete, you will also be notified of what additional information the Claims Administrator needs to allow or deny your claim, and you will be given 45 days after you receive the notice to provide the information during which time the claims submission deadline will be suspended.

Any notification that you receive from the Claims Administrator denying a claim that you have submitted will include:

1. the reason or reasons that your claim was denied;

2. the specific Plan provision on which the denial was based;

3. a description of any additional material or information that you would need to have your claim approved and an explanation of why that additional material or information is needed; and

4. information on the steps that you must take to appeal the Claims Administrator's decision, including your right to submit written comments and have them considered, your right to review, upon request and at no charge, relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

Appealing a Claim Denial

If the Claims Administrator denies your claim or any part of your claim, you or an authorized representative of yours may apply to the Claims Administrator's Operations Manager for the Plan to review the denial. Your appeal must be made in writing within 180 days after you received notification from the Claims Administrator that your claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to sue in court. Your written appeal

should state the reasons that you feel your claim should not have been denied. It should include any additional facts or documents that you believe to support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review, upon request and for no charge, documents and other information relevant to your appeal.

Decision on Review

The Claims Administrator's Operations Manager will review and decide your appeal in a reasonable time not later than 60 days after he or she receives your request for review. The Claims Administrator's Operations Manager may, in his or her discretion, hold a hearing of the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. You will be informed of the identity of any medical expert consulted in connection with your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include:

1. the specific reasons for the decision on review;

2. the specific Plan provision or provisions on which the decision is based;

3. a statement of your right to review, upon request and at no charge, relevant documents and other information; and

4. if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

UNDER WHAT CIRCUMSTANCES WILL I LOSE THE RIGHT TO SUBMIT CLAIMS?

You will continue to be a Participant until your death. After your death, your remaining HRA Account balance may continue to be used to reimburse your Spouse and Dependents for their medical expenses.

MISCELLANEOUS

CAN THE EMPLOYER TERMINATE OR CHANGE THE PLAN?

The Employer may amend or terminate the Plan at any time so long as such action does not violate the terms of any collective bargaining agreement between the Employer and a union that represents Plan Participants.

WHAT OTHER RULES APPLY TO MY PARTICIPATION?

MATERNITY BENEFITS

Under federal law, group health plans (including this Plan) and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that authorization be obtained from the plan or the insurance issuer for prescribing a length of stay not in excess of these periods.

THIS SUMMARY IS NOT MEANT TO INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. IN CASE OF A CONFLICT BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN,

THE PROVISIONS OF THE PLAN WILL ALWAYS GOVERN YOUR RIGHTS AND BENEFITS.