

**STARPOINT CENTRAL SCHOOL DISTRICT
HEALTH REIMBURSEMENT ACCOUNT PLAN**

FOR ACTIVE NON-TEACHER EMPLOYEES

PLAN SUMMARY

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The Starpoint Central School District maintains the Starpoint Central School District Health Reimbursement Account Plan for Active 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 Active 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 FOR ACTIVE NON-TEACHER EMPLOYEES 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, 2008. This Summary reflects the terms of the Plan as of 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?

To be eligible for the Plan, you may not be a member of the Starpoint Teachers Association. Also, you must be enrolled in a group major medical plan that has “minimum value” for purposes of the Affordable Care Act. This group major medical plan may be sponsored by your Employer, but that is not required. Your coverage may be from any source including, for example, your Spouse’s company.

If your group major medical plan coverage is from a source other than your Employer, you must provide the Plan with a written statement to that effect. An “Attestation” form obtained from the Plan Administrator must be used for this purpose.

If you have the required coverage as described above, you will qualify to receive benefits under this Plan by becoming a “Participant” on the first day you were eligible for coverage under the Employer’s group major medical plan (whether or not you actually elected it).

PLAN CONTRIBUTIONS

WHO PAYS FOR THE COST OF PLAN BENEFITS?

All benefits under the Plan are paid by the Employer. However, if you elect the COBRA or USERRA Continuation Coverage described below, you will be required to pay premiums to receive the coverage.

WHO PAYS FOR THE COST OF PLAN ADMINISTRATION?

The Employer pays the cost of Plan administration.

PLAN BENEFITS

WHAT BENEFITS MAY I RECEIVE UNDER THIS PLAN?

The purpose of the Plan is to reimburse you for a portion of your Eligible Expenses. An “Eligible Expense” is any expense for “medical care” (as defined in the Internal Revenue Code) that is not eligible for payment or reimbursement by any other health plan, with these exceptions:

1. The cost of over-the-counter medicines other than insulin is not covered.
2. Premiums for individual major medical health plan coverage are not eligible for reimbursement.
3. Premiums for group accident or health coverage are not eligible for reimbursement if you could elect to pay them on a pre-tax basis through a cafeteria plan offered by your Employer.

Eligible Expenses for the care of your Spouse and Dependents, if any, also are covered.

At the time you first become a Participant, the Employer will establish an HRA Account in your name. On that date and on each July 1st after that date while you remain a Participant, the Employer will credit your HRA Account with a certain number of “Benefit Dollars”. As you have Eligible Expenses, you can submit claims to the Plan for reimbursement of those expenses from the Benefit Dollars in your HRA Account.

If you are a nonunion employee, the amount of Benefit Dollars credited to your HRA Account on a particular date will be \$2,000. If you are a union employee, the amount of Benefit Dollars credited to your HRA Account on a particular date will be the amount specified in the collective bargaining agreement between your labor union and the Employer.

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?

Only the medical expenses of a Participant, a Participant’s Spouse or a Participant’s Dependent qualify 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.

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 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 Summary.

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

HOW DO I OBTAIN BENEFITS?

There are two ways to receive benefits under the Plan.

Debit Card Payment Method

When you become a Participant for the first time, you will receive a debit card to use. As you have Eligible Expenses, you can present your debit card to the provider of the goods or services (e.g., a doctor's office or a pharmacy). If the provider accepts the card, the provider will swipe the card in a manner similar to the way a credit card or bank debit card is swiped to pay for goods or services. Using your card in this manner will reduce your available account balance under the Plan by the amount of your purchase and will generate information regarding the transaction that automatically will be forwarded to the Claims Administrator.

These rules apply to your use of the debit card:

1. When you use the card to obtain benefits, you will be certifying to the Plan that you are using it only for payment of Eligible Expenses.
2. You are not excused from the legal requirement that every benefit payment by the Plan must be supported by information that shows who provided you with the eligible product or service, the date you received the product or service and the amount you paid for the product or service. If the information that the Claims Administrator receives electronically about an expense when you swipe the card to pay for that expense is not sufficient, then you will be required to provide the missing information.
3. You will not be required to provide any follow-up information for certain expenses that you have paid for using the card. These are: (a) expenses that match exactly a co-payment amount under your health insurance; (b) repeating expenses that have already been approved by the Plan such as prescription drug refills; and (c) expenses where the information that the Claims Administrator receives electronically when you swipe the card is detailed enough to adequately justify the payment without any further information

from you.

4. If you are required to provide additional support for an expense and fail to do so or if the Claims Administrator determines that an expense was ineligible for payment, you will be required to immediately repay the Plan. If you do not repay the Plan, the Employer will withhold the amount involved from your paycheck and, if necessary, the Plan will reduce your right to the payment of future claims. Also, you will lose the right to use the card.
5. You will lose the right to use the card immediately if you become ineligible for the Plan, even though you may have the right to submit further claims after you lose eligibility.

Claim Form Submission Method

You can also obtain reimbursement for Eligible Expenses 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 the extent to which the expenses are covered 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.

To insure timely reimbursement, please submit your claims directly to the Claims Administrator.

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

When a Claim is Denied

If your claim for benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits.

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 Claim 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 for the denial;
2. A reference to the provision of the Plan on which the denial was based;

3. A description of any additional material or information that would be needed to approve your claim and an explanation of why it is needed;
4. A description of the Plan's internal and external review procedures and the time limits applicable to such procedures; and
5. If the Claims Administrator relied on an internal rule, guideline, protocol or similar criteria in making its determination, either a copy of the specific rule, guideline or protocol, or a statement that such rule, guideline, protocol or similar criterion was relied on in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request.

Appealing a Claim Denial

You have the right to an internal appeal and, if applicable, an external review to an independent review organization.

An internal appeal must be submitted to the Claims Administrator and must include the following information:

1. Your name and address;
2. a statement that you are disputing a denial of a claim or the Claims Administrator's act or omission;
3. The date of the Claims Administrator's notice denying your claim; and
4. The reasons for your disputing the Claims Administrator's denial of the claim or the Claims Administrator's act or omission.

You should also submit any documentation not previously provided that supports your claim.

Your internal appeal must be delivered to the Claims Administrator within 180 days after you receive the denial notice or after the Claims Administrator's act or omission. Your internal appeal will be heard and decided by the Claims Administrator's Operations Manager.

If you do not file your internal appeal within this 180-day period, you lose your appeal rights

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 reason for the denial on review;
2. A reference to the provision of the Plan on which the denial was based;
3. A statement of your right to review, upon request and at no charge, relevant documents and other information; and

4. If the Claims Administrator's Operations Manager relied on an internal rule, guideline, protocol or similar criteria in making its determination, either a copy of the specific rule, guideline or protocol, or a statement that such rule, guideline, protocol or similar criterion was relied on in making the determination and that a copy of such rule, guideline, protocol or similar criterion will be provided to you free of charge upon request

External Appeals

You have the right to an external review of an internal appeal that is denied unless the denial was based on a failure to meet the Plan's eligibility requirements.

The Claims Administrator's Operations Manager will advise you of the process for requesting an external review when your internal appeal is denied. It must be filed within 4 months after you were provided with his or her response to your internal appeal request, or you will lose your right to request it.

The external reviewer must notify you and the Claims Administrator of its decision within 45 days after it receives your external appeal request. The decision is binding on all parties unless other State or Federal law remedies are available.

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

You will lose eligibility for the Plan if you stop working for the Employer and an eligible type of employee or if you cease to have the required group major medical coverage. When you lose eligibility:

1. You lose the right to have further Benefit Dollars credited to your HRA Account.
2. You will have 90 days after you lose eligibility to submit claims for the reimbursement of expenses you had before you lost eligibility for this Plan.
3. Any amount that continues to be credited to your HRA Account after processing of your final claims will be credited to an Account for your benefit under the Starpoint Central School District Health Reimbursement Account Plan for *Retired* Non-Teacher Employees, and your Account under this Plan will cease to exist.

MAY I VOLUNTARILY GIVE UP MY RIGHTS TO RECEIVE BENEFITS?

Yes, you may. During the last month of any Plan Year or at the time you cease to be eligible for the Plan, you may elect to opt-out of the Plan, in which case you will be waiving your right to future reimbursement of eligible expenses.

You may want to do this at some point so that you may purchase health coverage on a public health care exchange and receive government subsidies to help pay your premiums. To exercise this right to opt-out of this Plan, please contact the Plan Administrator to obtain a form that may be used for this purpose.

CONTINUATION COVERAGE

WHAT HAPPENS IF I GO OUT ON FMLA LEAVE?

The Family Medical Leave Act (“FMLA”) entitles certain employees to take unpaid leaves of absence totaling twelve weeks per year for specified personal or family health and child care needs. Your coverage under the Plan during any FMLA leave will continue at no cost to you. However, you will lose coverage (subject to your right to elect COBRA Continuation Coverage) if you fail to return to work at the end of the leave or if you give earlier notice of your intention not to return from the leave.

WHAT HAPPENS IF I TAKE MILITARY LEAVE?

If you take a leave of absence from the Employer in connection with duty in the uniformed services, the Plan will continue to cover you on the same basis as an active employee (except for expenses directly related to the military service, e.g., combat-related injuries) if the period of the leave is expected to be less than thirty one days. For leaves of a longer duration, you may elect to continue coverage in the plan at your own expense for up to twenty-four months. The “uniformed services” are the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in time of war or emergency.

MAY I CONTINUE MY PARTICIPATION IN THE PLAN IF I BECOME INELIGIBLE (BECAUSE, FOR EXAMPLE, MY EMPLOYMENT TERMINATES?)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), allows certain individuals to continue their health plan coverage at their own expense when that coverage otherwise would end. The purpose of this section of the Summary is to **explain the COBRA rules that could allow you to continue your coverage under the Health Reimbursement Account Plan for Active Non-Teacher Employees at the time you would otherwise lose eligibility.**

COBRA Coverage

COBRA coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You and your Spouse and Dependents, if any, all could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

If you elect COBRA coverage, you will receive the same coverage as active employees who have coverage under the Plan. You will also have the same rights that active employees have, including open enrollment and special enrollment rights.

As an employee, you will have a qualifying event if:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

Your Spouse will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;

4. You become enrolled in Medicare (Part A, Part B or both); or
5. The two of you become divorced or legally separated.

Your Dependent will have a qualifying event if:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become enrolled in Medicare (Part A, Part B or both);
5. You and your Spouse become divorced or legally separated; or
6. He or she stops being eligible for coverage under the Plan as a "Dependent".

Notifying the Plan Administrator of Qualifying Events

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), the Employer must notify the Plan Administrator of the qualifying event within 30 days after the event occurs.

When the qualifying event is divorce, legal separation or your child's loss of eligibility for coverage as a Dependent, you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. Failure to do so will result in a loss of eligibility for COBRA continuation coverage.

How to Provide Notice

Any notice that you provide regarding COBRA continuation coverage must be in writing. Notice of a qualifying event must include the name of the Plan, the name and address of the employee covered by the Plan, and the name and address of any qualified beneficiary. Your notice must also specify the qualifying event and the date it happened. If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

The Plan's form titled, "Notice of Qualifying Event", should be used to notify the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator.

You must mail your notice to the Plan Administrator unless you are otherwise instructed by the Plan Administrator. If mailed, your notice must be postmarked no later than the last day of the 60-day notice period.

See the information below regarding how the occurrence of a second qualifying event may affect the length of COBRA continuation coverage that is available. Any notice that you provide of a second qualifying event must include the same type of information that was included in your notice of the first qualifying event. The Plan's form titled, "Notice of Second Qualifying Event", should be used to notify the Plan Administrator of a second qualifying event. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the second qualifying event occurs.

See the information below regarding how a determination by the Social Security Administration that a qualified beneficiary is disabled may affect the length of COBRA continuation coverage that is available. Any notice of disability that you provide must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination that he or she is disabled. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form titled, "Notice of Disability Determination", should be used to notify the Plan Administrator of a disability determination. A copy of this form can be obtained from the Plan Administrator. Your notice must be mailed within 60 days after the Social Security Administration makes its determination and before the end of the first 18 months of COBRA continuation coverage.

Electing COBRA Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect COBRA coverage. For example, you and your Spouse may elect coverage separately. Also, you or your Spouse may elect coverage for your minor children.

A qualified beneficiary must elect coverage in writing within 60 days after it is offered, using the Plan's election form and following the procedures specified on the election form. Your election form must be provided to the Plan Administrator at the address indicated on the form. If you mail your form, it must be postmarked no later than the last day of the 60-day election period.

Even if you first reject COBRA coverage, you may change your mind and elect the coverage before the end of the 60-day election period.

Length of COBRA Coverage

When the qualifying event is your death, your enrollment in Medicare (Part A, Part B or both), your divorce or legal separation or your Dependent losing eligibility as a Dependent, COBRA coverage lasts for up to 36 months. When the qualifying event is the end of your employment or a reduction in your work hours and you became entitled to Medicare benefits less than 18 months before that qualifying event, COBRA coverage for other family members lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of your employment or reduction in your work hours, COBRA coverage generally lasts for up to 18 months. There are three ways in which this 18-month period of COBRA coverage can be extended.

Second qualifying event extension of 18-month period of COBRA coverage

An 18-month extension of coverage will be available to other family members if a second qualifying event occurs during the first 18 months of their continuation coverage. The maximum amount of total COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include your death, your divorce, your enrollment in Medicare or a child losing status as a Dependent.

If a second qualifying event occurs, you must notify the Plan Administrator in writing within 60 days to obtain the extension.

Medicare extension for Spouse and Dependents

If your employment ends or your work hours are reduced within 18 months after you become entitled to Medicare, the maximum coverage period for your Spouse and Dependents will end three years from the date you enrolled in Medicare.

Disability extension of 18-month period of COBRA coverage

An 11-month extension of coverage may be available if you or another family member receiving COBRA is disabled. For the extension to be available, the Social Security Administration (“SSA”) must determine that the family member was disabled during the first 60 days of COBRA coverage, and you must notify the Plan Administrator of that fact in writing within 60 days after the SSA's determination and before the end of the first 18 months of continuation coverage. If the disability extension is available, it will apply to the COBRA coverage of all family members, not just the disabled family member.

You must notify the Plan Administrator within 30 days if the SSA determines that the family member has stopped being disabled at any time before the extension coverage period ends. COBRA coverage for all qualified beneficiaries will terminate when this occurs. The plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Termination of COBRA Coverage before the End of the Maximum Coverage Period

Your COBRA coverage may be terminated before the end of the maximum period if (1) you fail to make any premium on time; (2) you become covered under another group health plan; (3) you enroll in Medicare; or (4) the Employer ceases to provide any coverage under the Plan.

You must notify the Plan Administrator in writing within 30 days, if, after electing COBRA coverage, you or another family member becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and to require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of COBRA coverage

The amount that you may be required to pay may not exceed 102% of the cost to the Plan of providing your coverage (150% during any disability extension).

Payment for COBRA coverage-First payment

If you elect COBRA coverage, you do not have to send any payment with your election form. Your first payment will be due within 45 days after the date of your election (This is the date your election form is post-marked, if mailed). If you do not make your first payment for COBRA coverage within 45 days, you will lose all of your rights to COBRA coverage.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the month before you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

Payment for COBRA coverage- Periodic payments

After you make your first payment for COBRA coverage, you will be required to pay for each subsequent month of

coverage. These payments are due on the first day of each month of coverage. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will notify you of the payments due for these coverage periods. A notice is only a reminder to you to pay. It is not a bill. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Grace periods for periodic payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days to make each payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. However, if you make a monthly payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If You Have Questions

If you have questions about your COBRA coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or Employer Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and Employer EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

To protect your rights, you should notify the Plan Administrator if you change your address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

MISCELLANEOUS

WHAT HAPPENS IF MY EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER A CAFETERIA PLAN OF THE EMPLOYER?

If you have an expense that is an eligible expense under a cafeteria plan as well as under this Plan, the expense must be reimbursed by the cafeteria plan to the extent that you are eligible for reimbursement of expenses under that plan.

CAN MY EMPLOYER TERMINATE OR CHANGE THE PLAN?

The Employer may amend or terminate the Plan only under circumstances that will 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.