SYRACUSE CITY SCHOOL DISTRICT

FLEXIBLE SPENDING ACCOUNT PLAN

(With Pre-Tax Insurance Premiums)

SUMMARY PLAN DESCRIPTION

Of the Provisions of the Plan
in Effect on January 1, 2019

INTRODUCTION

This Summary Plan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection at the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210, during regular business hours.

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM"). Check to see if there are any SMM's attached when you refer to this SPD.

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	Syracuse City School District Flexible Spending Account
Plan Number:	510
Plan Type:	Cafeteria (Section 125) Plan
Plan Year:	The Plan Year begins on January 1 and ends on the following December 31
Employer and Plan Sponsor:	Syracuse City School District 725 Harrison Street Syracuse, New York 13210 315-435-4171
Employer Identification Number:	15-6010157
Affiliated Employers:	None
Plan Administrator:	Syracuse City School District 725 Harrison Street Syracuse, New York 13210 315-435-4171
Type of Plan Administration:	The Plan is administered by the Employer through a Committee appointed by the Employer. All benefits are paid from the general assets of the Employer. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. The Office of Human Resources is the primary source for information about these aspects of the Plan.
Plan Agent for Service of Legal Process:	Syracuse City School District 725 Harrison Street Syracuse, New York 13210 Legal process may also be served upon the Plan Administrator.

1. What is the purpose of the Plan?

Eligible employees can make pre-tax contributions to the Plan that are credited to their Plan account(s) and may be used to pay or reimburse them for the following types of expenses, provided the expenses are not payable or reimbursable from any other source:

- dependent care expenses that would otherwise qualify for a dependent care credit on your federal income tax return if they were not paid or reimbursed under the Plan. You must designate the amount you wish to contribute for dependent care expenses. These contributions will be credited to an account that can be used only for dependent care expenses.

- health care expenses (other than insurance premiums and expenses for long-term care services) that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of health care expenses required to take a deduction), incurred for you, your spouse, any person who qualifies as your dependent for federal income tax purposes, or your child even if he or she does not qualify as your dependent for federal income tax purposes but only through the end of the calendar year in which the child reaches age 26. Health care expenses also include the cost of over-the-counter medicines and drugs (such as antacid, allergy medicine, pain reliever and cold medicine) provided, the over-the-counter medicine or drug is either insulin or is prescribed (without regard to whether such medicine or drug is available without a prescription). Whether a medicine or drug is a prescribed medicine or drug is determined in accordance with regulations and other guidance issued by the Internal Revenue Service. Health care expenses do not include toiletries, cosmetics, sundry items, dietary supplements, vitamins and other items that are merely beneficial to a person's general health. You must designate the amount you wish to contribute for health care expenses. These contributions will be credited to an account that can be used only for health care expenses.

These contributions are deducted from employees' pay and are not reported as taxable income on their W-2 forms, so they do not pay federal income tax or Social Security taxes on them, if the Plan continues to satisfy certain tax requirements. Before you can participate in the Plan, and before the beginning of each Plan Year, you will be notified of the minimum and maximum amount you can contribute for these expenses for that Plan Year. (For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.) The Plan limits the amount participants can contribute on a pre-tax basis for any Plan Year for payment or reimbursement of health care expenses. Generally, this limit is intended to equal

the maximum amount permitted by the IRS, which the IRS increases from time-to-time for increases in the cost-of-living. However, if the IRS does not announce an increase in time to adjust the Plan's administrative procedures and Employer's payroll systems for the increase before the beginning of a Plan Year, the Plan limit will not be increased until the next Plan Year. For the current Plan Year, the limit is $2,750.00 for 2019 and $2,750.00 for 2020.

Eligible employees can also pay their premiums through the Plan, on a pre-tax basis, for the following group health coverage sponsored by the Employer:

- dental coverage
- medical coverage
- vision coverage.

(An employee's cost for coverage is referred to in this SPD as his "premium" whether the coverage is provided through an insurer or is self-insured by the Employer.) The premiums employees pay through the Plan are deducted from their pay and are not reported as taxable income on their W-2 forms, so they do not pay federal income tax or Social Security taxes on them, provided the Plan satisfies certain tax requirements.

2. Who is eligible to participate in the Plan?

To participate, you must be: (i) an employee of the Employer or an Affiliated Employer that has adopted the Plan (both are referred to herein as Employer); (ii) among the employees to whom the Employer makes available group health plan coverage which meets certain requirements under the Affordable Care Act; and (iii) satisfy any other eligibility requirements described below. Notwithstanding the above, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation ("LLC"), any member of the LLC; and (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer. In addition, any employee participating in another Flexible Spending Account Plan maintained by the Employer which has health flexible spending accounts compatible with the tax requirements to be eligible to contribute to a health savings account cannot also participate in this Plan at the same time.

Any employee is eligible to participate in the Plan and make contributions for the following types of expenses, and/or pay premiums for the following group coverage sponsored by the Employer, through the Plan:

- dependent care expenses
- health care expenses
- dental coverage
- medical coverage
- vision coverage

if he satisfies the following additional requirement(s):

per the District's collective bargaining agreements.

Such employee can participate in the Plan, and make such contributions and/or pay such premiums, through the Plan on the first day of the month following his employment commencement date; provided he has completed and filed all of the forms required for participation by the Committee.

The Employer will notify an employee before, or as soon as administratively practical after, the Employee satisfies the requirements for eligibility.

3. Are there any other requirements to participate in the Plan?

If you are eligible to participate in the Plan, your premiums will automatically be deducted from your pay and paid through the Plan throughout the Plan Year, unless you elect otherwise in writing signed by you and filed with the Committee. (For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.) If you file this election, you will not be able to pay your premiums through the Plan until the next Plan Year, unless a change in status occurs that allows you to change this election (see Question & Answer 4). To make contributions to the Plan for other expenses you must complete an enrollment process, and elect the amount of your contributions to the Plan for the Plan Year. Contributions for these expenses are also deducted from your pay throughout the Plan Year. Failure to complete enrollment by the date specified by the Committee will be considered an election not to make contributions for the Plan Year for these expenses. In that case, you will not be able to make contributions for these expenses until the next Plan Year, unless a change in status occurs that allows you to change your election (see Question & Answer 4).

4. When can I change the amount I put into the Plan?

You can change the premiums you pay through the Plan, and your contributions for other expenses, before the beginning of each new Plan Year. Once the Plan Year has started, federal tax laws permit you to change these amounts only when one of the following "changes in status" occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or special enrollment or disenrollment rights under a state Children's Health Insurance Program (CHIP). (This applies only to elections for group health coverage premiums.)

- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan sponsored by your Employer. (This applies only to elections for group health coverage premiums.)

- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage. (This applies only to group health coverage premium elections and health care expense elections.)

- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines). (This applies only to elections for group health coverage premiums.)

- Your premiums increase significantly. (However, if there is an ordinary increase or decrease in premiums, the premiums you pay through the Plan will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or your contributions for other expenses.

- There is a significant curtailment in, or cessation of, group coverage for employees generally. Note, that a significant curtailment in, or cessation of, your coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan.

- A new group coverage option is added or a group coverage option you have selected is eliminated. Note, that the addition or elimination of a coverage option allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or your contributions for other expenses.

- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).

- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).

- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for coverage under the Plan or the same type of coverage under another employer plan. However, if your employment terminates and resumes in the same Plan Year within a period of 30 days or less, the amount of premiums you paid through the Plan before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in the premiums you pay through the Plan.

- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note, a change in residence allows you to change the amount of the premiums you pay through the Plan for group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or your contributions for other expenses.

- Your dependent's eligibility for group health coverage changes due to the dependent's age, student status or marital status or similar circumstance.

- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Plan.

- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care

program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan. (This applies only to elections for group health coverage premiums.)

- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.

- A person's status as a dependent for purposes of your dependent care election changes.

- You: (i) have been reasonably expected to average at least thirty (30) hours of service per week for the Employer and there is a change in your employment status such that you will no longer reasonably be expected to average at least thirty (30) hours of service per week for the Employer after the change; and (ii) you represent to the Employer or Committee that you and related individuals who cease medical coverage due to the revocation, have enrolled (or intend to enroll) in other group health plan coverage which satisfies the requirements for minimum essential coverage under the Patient Protection and Affordable Care Act, effective no later than the first day of the second month following the month that includes the date the medical coverage is revoked. (This applies only to a prospective revocation of a Contribution election to pay for medical coverage through the Plan (even if the change does not result in you ceasing to be eligible for medical coverage).)

- You: (i) are eligible to enroll in a qualified health plan through an exchange established under the Patient Protection and Affordable Care Act during an exchange's special enrollment period or annual open enrollment period; and (ii) you represent to the Employer or Committee that you, and any related individuals who cease coverage due to such revocation, have enrolled (or intend to enroll) in a qualified health plan through the exchange effective no later than the day immediately following the last day of your medical coverage. This applies only to a prospective revocation of a Contribution election to pay for medical coverage through the Plan.)

Note that any election to change the amount of premiums you pay through the Plan or your contributions for other expenses must be made within 30 days after, and must be consistent with, an event described above. Also, even if you are allowed to change your contribution for health care expenses, you may not reduce the annual contribution elected to less than the amount of health care expenses already reimbursed to you for the Plan Year.

5. How do I receive my benefits from the Plan?

Amounts are deducted directly from your pay and used to pay your premiums. Your employer may make arrangements for automatic payment or reimbursement of other expenses covered under the Plan. Otherwise, these expenses will be paid/reimbursed at least monthly, provided you file a written claim for payment or reimbursement at least five business days before a scheduled payment/reimbursement date. The Committee will inform participants of the scheduled payment/reimbursement dates. Claims for payment or reimbursement must be made on forms provided by the Committee. You may request forms from the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210.

The Employer may also make arrangements for expenses to be paid and processed using a pre-paid "debit" card. Expenses paid or reimbursed in this manner must be substantiated as an expense qualifying for payment or reimbursement under the Plan in accordance with federal tax law. If an expense cannot be substantiated, the Employer will take action consistent with tax regulations to require the participant to repay the unsubstantiated amount, including: (i) denying the participant access to a pre-paid card (and requiring him to submit written forms for future claims) until the unsubstantiated amount is recovered; (ii) demanding that the participant repay the unsubstantiated amount; (iii) deducting the unsubstantiated amount from the participant's wages; and (iv) offsetting payment of other claims for expenses incurred in the same Plan Year by the unsubstantiated amount. If these efforts are unsuccessful, the participant will remain indebted to the Employer for the unsubstantiated amount. The Employer or Plan Administrator may adopt other rules for the use of pre-paid cards, such as suspending or terminating participation in the Plan for misuse of a pre-paid card, canceling a person's pre-paid card when he ceases participation in the Plan, establishing transaction limits or restrictions on the pre-paid card, and charging fees for the use of pre-paid cards.

If a participant attempts to have an expense paid through a pre-paid card but, for any reason, it is not successfully processed, he should submit a written claim for the expense. A claim for the expense is not considered denied until he submits a written claim and the written claim is denied in accordance with the claims procedures described in the Answer to Question 12.

Note:

- The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Plan for dependent care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.

- The amount of health care expenses paid or reimbursed cannot exceed the amount of your health care expense contribution election for the Plan Year, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.

- Only expenses incurred on or after the date you begin participating in the Plan, and before the date you stop participating in the Plan, are covered under the Plan. Generally, you stop participating in the Plan when you are no longer an eligible employee of the Employer. (See Question and Answer 2.) In addition, any expenses incurred after you stop making Plan contributions for those expenses are not covered.

- If you are employed through the end of the Plan Year, you have until 90 days after the end of each Plan Year to submit a claim for payment or reimbursement for expenses that you incurred during the Plan Year. (Question & Answer 7 explains rules that apply when you terminate employment before the end of a Plan Year.)

- Amounts paid under the Plan are not treated as additional compensation to an employee for purposes of determining contributions or benefits under any qualified retirement plan maintained by the Employer, or for purposes of any other benefit obligations of the Employer, unless otherwise provided under the terms of the retirement plan or other benefit program.

By January 31st of each year, you will receive a W-2 Wage and Tax Statement showing the amount of your contributions to the dependent care portion of the Plan for the previous calendar year.

6. What happens if I am employed by the Employer through the end of a Plan Year but my contributions are greater than my actual expenses during the Plan Year?

If the amount you contribute for expenses exceeds the amount of those expenses you actually incur during the Plan Year, you will forfeit the excess contributions. Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year.

7. What happens if my employment terminates before the end of a Plan Year?

You may claim payment or reimbursement for expenses incurred before your termination, provided you submit your claim for payment or reimbursement no later than 90 days after your termination. You may also have a right to COBRA

continuation coverage. (See "COBRA Continuation Coverage" in Question and Answer 13.)

8. What happens if I take a leave of absence during the Plan Year?

A paid leave of absence is not itself a change in family status, so your elections will stay in place unless you have another reason to change them. However, a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your elections as explained in Question & Answer 4. Also, see Question & Answer 13 for special rules applicable to a leave under the Family and Medical Leave Act and the Uniform Services Employment and Reemployment Rights Act.

9. Can the Employer amend or terminate the Plan?

The Employer can amend or terminate the Plan at any time, but will notify you in advance. Amendment or termination of the Plan will not affect your right to payment or reimbursement for expenses incurred before the date of the change. The Employer may also take action to assure compliance with nondiscrimination requirements and limitations that apply to the Plan under federal tax law, including reducing contributions made by certain highly compensated individuals and/or key employees in order to satisfy those requirements and limitations.

10. Can a person's coverage under the Plan ever be rescinded?

A person's coverage under the Plan may be rescinded (i.e., retroactively cancelled or discontinued) if the person (or a person who sought coverage for the covered person) performed an act, practice, or omission that constitutes fraud, or made an intentional misrepresentation of fact, to get the Plan coverage. Any person whose coverage is rescinded will receive at least 30 days advance written notice before his coverage is rescinded. Rescission of a person's coverage is considered an adverse benefit determination for purposes of the Plan's claims procedures described in the Answer to Question 12.

11. Who controls the operation of the Plan?

A Committee appointed by the Employer controls and manages the operation of the Plan. The Committee decides all questions arising in the interpretation and application of the Plan, and may establish rules for the operation of the Plan.

12. What if I have questions about coverage or benefits, or want to make a claim for benefits?

You should contact the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210 if you have questions about any group coverage sponsored by the Employer. Claims for group coverage benefits should be filed in accordance with the procedures applicable to that coverage. See the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210 if you need information on how to file a claim for a group coverage benefit.

You should contact the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210 if you have questions about the operation of this Plan.

If you disagree with a decision concerning your right to participate in the Plan or wish to make a claim for a benefit, you may file a claim in writing with the Committee. If you wish, you may appoint someone to file the claim and act on your behalf, provided you give the Committee signed written notification of the appointment. The claim procedure is different depending on whether the claim is related to a health care expense or is any other type of claim. If any part of the claim is denied, the Committee will provide you with a written notice, within 30 days after the receipt of a health claim or 90 days after the receipt of any other type of claim. However, if an extension is necessary due to reasons beyond the Committee's control, the time to make the determination may be extended for up to another 15 days for a health claim or 90 days for any other type of claim. (If an extension for a health claim is necessary because additional information is needed from you, then you will be given 45 days from the date you receive the notice to provide the information.) In any case, you will receive written notice of the reasons for the extension, any additional information required for the Committee to make the determination, and the date the determination is expected.

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; and (iv) a description of the Plan's review procedures and time limits. In the case of a health claim, the notice will also state the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the

determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of health claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; and (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request.

If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

13. What additional rights do I have as a participant?

Federal law gives you rights with regard to coverage and certain specific benefits. The following is a summary of those rights.

COBRA Continuation Coverage

You may have a right under "COBRA" to continue to participate in the health care expense portion of the Plan only after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become

available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

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 below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage 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 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 the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

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 within 60 days after the qualifying event occurs. You must provide this notice to: Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. 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.

COBRA continuation coverage is a temporary continuation of coverage, which lasts no longer than the last day of the Plan Year in which the qualifying event occurs. Furthermore, COBRA continuation coverage is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to payment or reimbursement for health care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

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.

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210.

Uniformed Services Employment and Reemployment Rights Act Continuation Coverage

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continue to participate in the health care expense portion of the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. However, USERRA continuation coverage will terminate if the employee's military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

The procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage rules and deadlines described in the SPD, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

Health Insurance Portability and Accountability Act of 1996 and Uniformed Services Employment and Reemployment Rights Act

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Information concerning your HIPAA and USERRA rights is available from Lisa A. Wade, Syracuse City School District, 725 Harrison Street, Syracuse, New York, 13210, phone 315-435-4171, fax 315-435-4163.

Family and Medical Leave Act

If you are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue your contributions during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you notify the Employer that you will not return to work. If you choose not to continue coverage during an FMLA Leave, you may resume Plan contributions when the FMLA Leave expires, provided you are still an employee eligible to participate in the Plan (see Question and Answer 2).

Information concerning your right to and obligations during a leave is available from the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York 13210.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care

provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact Lisa A. Wade, Syracuse City School District, 725 Harrison Street, Syracuse, New York, 13210, phone 315-435-4171, fax 315-435-4163.

Court Order or State Agency Notice Regarding Medical Child Support

If the Plan receives a court order or notice from a state agency requiring you to provide a child or children with health coverage, you will be contacted about the procedure under which the Plan Administrator will determine if the order or notice satisfies certain requirements under federal law. If it does, the Plan must comply with the order or notice. Copies of these procedures are available, without charge, from the Office of Human Resources, Syracuse City School District, 725 Harrison Street, Syracuse, New York, 13210.