SYRACUSE CITY SCHOOL DISTRICT
FLEXIBLE SPENDING ACCOUNT

SUMMARY PLAN DESCRIPTION

July 1, 2021

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TABLE OF CONTENTS

INTRODUCTION

Syracuse City School District (the "Company") established the Syracuse City School District Flexible Spending Account (the "Plan") effective 01/01/2019. This summary describes the Plan as amended and restated effective 07/01/2021. The Plan is a cafeteria plan that provides an eligible employee with the opportunity to choose among benefits offered under the Plan.

This summary supersedes all previous summaries of the Plan. Although the purpose of this document is to summarize the more significant provisions of the Plan, it is only a summary - the terms of the Plan document ultimately govern the operation and administration of the Plan. The Company and any employer who has adopted the Plan is referred to in this document as the "Company".

ELIGIBILITY

You are an "Eligible Employee" if you are an employee of the Company or any affiliate who has adopted the Plan who is listed on the Company's payroll and personnel records as an employee and based on your bargaining unit's contract/employment agreement with the Syracuse City School District ("District") on the first day of the calendar month next following the date you complete at least one (1) hour of service for the District (your "Employment Commencement Date"). The age and service requirements for the Plan are further modified by the following: An employee will be considered an Eligible Employee for the purposes of the Health Flexible Spending Account Plan per the District's collective bargaining agreements listed below:

Bargaining Unit	FSA Eligible?	Effective Start Date of FSA Enrollment	Notes
01	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program
02	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program
03	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program
05	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	
06	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	
07	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	
08	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program
09	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program
10	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program
11	No	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	
12	Yes	Next available payroll following completion of application by employee and account verification by Lifetime Benefit Solutions	Employee not eligible to enroll in the FSA Medical Program if eligible for the HSA Program

However, you are not an "Eligible Employee" if you are any of the following:

- A self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.
- A leased employee.
- A non-resident alien who received no U.S. source earned income.

If you are eligible to participate in the Company-sponsored group health plan, then you are eligible to participate in the Health Flexible Spending Account, even if you do not elect to participate in the Company-sponsored group health plan.

If you elect to participate in the General Health FSA then you are not eligible to contribute to an HSA-Compatible Health FSA, unless you elect to convert your General Health FSA. You must be enrolled in a high deductible health plan to be eligible to contribute to the Health Savings Account for the month. If you elect to participate in a General Health FSA for the Plan Year you are not eligible to participate in the HSA Benefit.

Rehire Provision

If your employment terminates and resumes in the same Plan Year within a period of 30 days or less, the election you had in effect prior to your termination will automatically be reinstated upon resumption of your employment. If your employment resumes in the same Plan Year more than 30 days after your employment terminates, you will once again be required to satisfy the eligibility requirements for participation in the Plan and make a new election.

ELECTION PROCEDURES

You may elect to participate in the Benefits under the Plan within 30 days after your eligibility date (or a shorter period if established by the Plan Administrator).

If you do not enroll in the Plan upon your initial eligibility, you may enroll during the enrollment period established by the Plan Administrator. Your election will be effective as of the first day of the Plan Year following the enrollment period.

You may also enroll in the Plan upon a change in status event as described below.

To enroll in the Plan, you may need to submit a completed election form to the Plan Administrator on or before the date specified by the Plan Administrator. If, as of the start of a Plan Year, you have not submitted a completed election form by its due date, you will be deemed to have elected not to participate in the Plan for that Plan Year.

An election to participate in the Plan is generally irrevocable for the Plan Year. You may not change your election during a Plan Year unless you experience a change in status. Your change in election must be on account of and correspond with a change in status that affects your eligibility for coverage under the Plan.

Depending on the Benefit, a "change in status" includes:

- Change in your marital status.
- Change in the number of your dependents.
- Change in your employment status or the employment status of your spouse or dependents.
- Your dependent satisfies or ceases to satisfy eligibility requirements.
- Change in your place of residence.
- Commencement or termination of an adoption proceeding.
- Court judgment, decree, or order.
- Entitlement to Medicare or Medicaid by you, your spouse, or your dependent.
- Significant cost or other coverage changes.
- You change coverage under another cafeteria plan.
- You take leave under the FMLA.
- You lose coverage under the group health plan due to a reduction in hours.
- You are eligible to enroll in a qualified health plan through the Marketplace.

BENEFITS

Contributions pertaining to a Benefit will be credited to the applicable account. Your contributions to the Plan are not subject to federal income tax or social security taxes. Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the Plan. For instance, participation in the Plan may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in this Plan.

If you are a highly paid employee or an owner of your Company, federal law may impose limits on your behalf to participate in the Plan and/or the benefits you may receive from the Plan. If the Plan Administrator determines that the Plan may fail to satisfy any nondiscrimination requirement or any limitation imposed by the Code, the Plan Administrator may modify your election in order to assure compliance with such requirements or limitations.

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts sponsored by the Company as permitted by applicable law.

Health Flexible Spending Account (Health FSA)

The following Health Flexible Spending Account is available under the Plan:

- General Purpose Health FSA

General Purpose Health FSAs may only be used to reimburse for qualifying medical expenses during the Plan Year.

If you are eligible, you may elect to contribute to a Health FSA in accordance with the "Election Procedures" described above.

Health FSA Eligibility

Please be aware that there are some limitations on your eligibility to participate in Health FSAs. If you are an Eligible Employee, you are eligible to contribute to a Health FSA. However, if you are not eligible to participate in the Company-sponsored group health plan, then you are not eligible to participate in a Health FSA.

Additionally, if you elect to participate in the Health Savings Account you are not eligible to participate in the General Purpose Health FSA Benefit.

Health FSA Contributions

Your Health FSA will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount you may contribute each year to your General Purpose Health FSA and/or HSA-Compatible Health FSA is the maximum amount permitted under the tax code ($2,850 for 2022). The Company will not make additional contributions to your General Purpose Health FSA on your behalf.

Health FSA Eligible Expenses/Reimbursement

You will be entitled to receive reimbursement from your General Purpose Health FSA for eligible expenses incurred by you, your spouse and dependents, if any. A dependent is generally someone you may claim as a dependent on your federal tax return and also include a child until the last day of the calendar year in which they turn 26. The entire annual amount you elect to contribute for the Plan Year to your Health FSA, less any reimbursements already distributed from your Health FSA, will be available for reimbursement throughout the Plan Year.

You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your Health FSA. Eligible expenses generally include all medical expenses that you may deduct on your federal income tax return. Health insurance premiums are not an eligible expense for the Health FSA.

You will not be reimbursed for any expenses that were (1) incurred before you are eligible to participate in the Health FSA; (2) incurred after you have become ineligible to participate in the Health FSA and are attributable to a tax deduction you took in a prior taxable year; or (3) covered, paid, or reimbursed from another source. Your claim for reimbursement must include substantiation that the Plan Administrator or Claims Administrator considers sufficient for determining that the claim constitutes an expense eligible for reimbursement under the Plan.

You must submit claims for reimbursement from your General Purpose Health FSA no later than 90 days after the end of the Plan Year. Any amounts remaining in your Health FSA after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your FSA will end as of your date of termination. You may submit claims for reimbursement from your FSA for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your Health FSA no later than 90 days after the date your employment terminates. Any balance remaining in your Health FSA will be forfeited after claims submitted prior to this date have been processed.

Dependent Care Assistance Plan Account (DCAP)

A Dependent Care Assistance Plan Account may be used to reimburse expenses incurred for the care of a qualifying dependent. If you are eligible, you may elect to contribute to a DCAP Account in accordance with the "Election Procedures" described above.

DCAP Contributions

Your DCAP Account will be credited with your contributions and will be reduced by any payments made on your behalf. The maximum amount that you may contribute each year to your DCAP Account is the maximum amount permitted under the tax code ($5,000 for 2022, $2,500 if you are married and filing separately.)

The Company will not make additional contributions to your DCAP Account on your behalf.

DCAP Eligible Expenses/Reimbursement

The amount available for reimbursement is the balance in your DCAP Account at the time the reimbursement request is received by the Claims Administrator. You may receive reimbursement for eligible expenses incurred during the Plan Year when you are participating in your DCAP Account. Eligible expenses generally include those that you incur in order to be gainfully employed and for the care of (i) your dependent who is under age 13, or (ii) your spouse or dependent who lives with you and who is physically or mentally incapable of caring for themselves. Expenses incurred for overnight camp are not eligible for reimbursement. A dependent is generally someone who you may claim as a dependent on your federal tax return.

You must submit claims for reimbursement from your DCAP Account no later than 90 days following the Plan Year. Any amounts remaining in your DCAP Account at the end of the Plan Year after all timely claims have been paid will be forfeited.

Termination of Employment

If you terminate employment with the Company for any reason during the Plan Year, your contributions to your DCAP Account will end as of your date of termination. You may submit claims for reimbursement from your DCAP Account for expenses incurred during the Plan Year prior to your termination of employment. You must submit claims for reimbursement from your DCAP Account no later than 90 days after the date your employment terminates. Any balance remaining in your DCAP Account will be forfeited after claims submitted prior to this date have been processed.

CLAIMS PROCEDURES

You must submit your claim for benefits in accordance with the Plan Administrator's guidelines. Claims must be submitted to Lifetime Benefit Solutions, Inc. at:

Address: P.O. Box 211126, Eagan, MN 55121
Phone number: 800-327-7130

Any claim for benefits must include all information and evidence that the Plan deems necessary to properly evaluate the merits of the claim. The Plan may request any additional information necessary to evaluate the claim.

To the extent that the Plan approves a claim, the Plan may either (i) reimburse you, or (ii) pay the service provider directly. The Plan will pay claims at least once per year. The Plan may provide that payments/reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments/reimbursements outstanding at the end of the Plan Year will be reimbursed without regard to the minimum payment amount.

Claims for Plan Benefits (except for Health FSAs)

You must file a claim for benefits under this Plan in accordance with the Plan Administrator's guidelines. If your claim does not include enough information to process the claim, you will be given an opportunity to provide the missing information. You may designate an authorized representative by providing written notice of the designation to the Plan.

You may apply for benefits under the Plan by completing and filing a claim with the Plan. Your claim must include all information and evidence that the Plan deems necessary to evaluate the merit of your claim and to make any necessary determinations on your claim. The Plan may request any additional information from you as necessary to evaluate the claim.

Claims for Health FSA Benefits

If you file a claim for benefits from your Health FSA and that claim is denied, the Plan will notify you within a reasonable period of time, but no later than 30 days after the Plan received the claim. The Plan may notify you, prior to the expiration of this 30-day period, of the need to extend the period by up to 15 days due to matters beyond its control. In such case the Plan will notify you of the circumstances requiring the extension of time and the date by which the Plan will notify you of its decision. If the extension is necessary because you did not submit information necessary to decide the claim, the notice of extension will describe the required information, and you will have at least 45 days from the day you receive the notice to provide the specified information.

If your claim is denied, the Plan will provide you with a notice identifying (A) the reason or reasons for the denial, (B) the Plan provisions on which the denial is based, (C) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (D) an explanation of the steps that you must take if you wish to appeal the denial. The notice will also include (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or (2) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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.

Appeal of Denied Claim. If you wish to appeal the denial of a claim, you must file an appeal with the Plan on or before the 180th day after you receive the Plan's notice that the claim has been denied. You will lose the right to appeal if the appeal is not made within this 180-day period. The appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will be provided, upon request and free of charge, documents and other information relevant to your claim. Your appeal may also include any comments, statements or documents that you desire to provide. The Plan will consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan may deem relevant. All appeals must be submitted to the following:

Lifetime Benefit Solutions. Inc.
Attention: Appeals Department
P.O. Box 211011
Eagan, MN 55121

In considering the appeal, the Plan will:

(A) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(B) Provide that, in deciding an appeal of any denial that is based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(C) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in making the denial; and

(D) Provide that the health care professional engaged for purposes of a consultation under (B) above will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual.

The Plan will notify you of the Plan's benefit determination on review within 60 days after receipt by the Plan of your request for review of the denial.

Denial of Appeal. If your appeal is denied, the Plan will provide you with a notice identifying (A) the reason or reasons for such denial, (B) the Plan provisions on which the denial is based, (C) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (D) a statement describing the Claimant's right to bring an action for judicial review and to the external appeals process. The determination rendered by the Plan shall be binding upon all parties.

Exhaustion of Remedies; Limitations Period for Filing Suit. Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

Benefits Provided under Contracts. Please see the underlying contracts for any additional claims and reimbursement rules under those contracts.

Debit/Credit Cards

Syracuse City School District will provide you with a debit/credit and/or other stored-value card for purposes of making purchases that are eligible for reimbursement from your Health Flexible Spending Account and/or Dependent Care Assistance Plan Account. The Plan Administrator will provide you with more information about these cards as well as any limitations at the time you enroll in the Plan. You do not have to use the cards and may request reimbursements as listed above.

Claims Not Governed by this Summary

HSA Claims. Claims relating to the HSA are administered by your HSA trustee/custodians in accordance with the HSA trust or custodial document.

COBRA CONTINUATION COVERAGE

If you are participating in the Health FSA and your Company is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs fewer than 20 employees, but you should contact the Plan Administrator who can inform you if the Company is a small employer not subject to COBRA and is not required to comply with these rules. Depending on your Health FSA balance at the time of the Qualifying Event (described below), you may not be eligible for COBRA continuation coverage.

Qualifying Events

You have the right to continue your coverage under the Health FSA if any of the following events results in your loss of coverage under the Health FSA:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Health FSA if any of the following events results in their loss of coverage under the Health FSA:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."
If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Health FSA for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice which explains your rights regarding COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if they are not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of their COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Health FSA until the end of the Plan Year in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Health FSA;
- The date that you first become entitled to Medicare; or
- The date the Company no longer provides a Health FSA to any of its employees.

MISCELLANEOUS

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving health care benefits. Contact the Plan Administrator for more information under the Plan.

Unclaimed Reimbursements

Payments from the Account that are not claimed on a timely basis (for example, checks issued from the Plan that are not timely cashed) will be forfeited and returned to the Plan. Please contact your Plan Administrator about what constitutes "timely" claims of payment from the Plan.

Excess Payments/Reimbursements

If you receive an excess benefit or payment under the Plan, you must immediately repay any such excess payments/reimbursements. You must also reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable to you under this Plan.

Beneficiaries

If you die, your beneficiaries or your estate may submit claims for eligible expenses for the portion of the Plan Year preceding the date of your death. You may designate a specific beneficiary for this purpose. If you do not name a beneficiary, the Plan Administrator may pay any amount to your spouse, one or more of your dependents, or a representative of your estate.

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Loss of Benefit

You may lose all or part of your Account(s) under the Plan if the unused balance is forfeited at the end of a Plan Year and if we cannot locate you when your benefit becomes payable to you.

Non-Alienation of Benefits

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary to receive benefits under the Plan in the event of your death.

Amendment and Termination of the Plan

The Company may amend or terminate the Plan at any time.

Plan Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding on all persons and parties.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Governing Law

The Plan is governed by the laws of New York to the extent not pre-empted by Federal law.

<u>Tolling of Certain Timeframes</u>

Effective as of March 1, 2020, the following provision is added to the Plan:

Tolling of Certain Timeframes. With respect to the Health Flexible Spending Account component of the Plan, the Plan will disregard days occurring during the "Outbreak Period" (as defined below), for purposes of determining the date by which an individual (e.g., a Participant, claimant, Spouse, Dependent, qualified beneficiary) has to:

a. elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;

b. make an initial or any subsequent COBRA premium payment if the time period (including the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;

c. provide a required notice to the Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day

of the Outbreak Period;

d. file an initial claim for benefits under the Plan if the timely filing period otherwise would include any day of the Outbreak Period; or

e. file an internal appeal in response to an adverse benefit determination if the time period for filing an internal appeal otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (a)-(e) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior to March 1, 2020 will be subtracted from the time period that would apply without the extension to determine the remaining time frame in which a covered person has to act after the end of the Outbreak Period. For example, for a special enrollment request that is subject to a 60-day initial election period, if the initial election period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 60-day period (leaving 46 days in the initial election period), (ii) the entire Outbreak Period (March 1, 2020 through February 28, 2021) will be disregarded and (iii) the initial election period will end 46 days after the end of the Outbreak Period, on April 15, 2021.

Coverage with respect to (a), (b) and (c) above, may be retroactive to the date of the qualifying event; provided the covered person makes any required premium payments prior to the end of the extended time period provided for above.

For purposes of this section, the "Outbreak Period" is the period beginning on the later of (1) March 1, 2020 or (2) the "Applicable Event Date" (as defined below) and ending on the earlier of (A) one year from the Applicable Event Date or (B) 60 days after the announced end of the "National Emergency" described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the "Agencies")) and will be interpreted to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020 (and any subsequent guidance from the Agencies). The "National Emergency" for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period with respect to a specific event or all events, if applicable, will be interpreted to end on the date that is determined by the Plan Administrator to be appropriate for the Plan. In no case will the Outbreak Period for any event last longer than one year or begin before March 1, 2020 or after the date described in (B) above.

For purposes of this section, the "Applicable Event Date" is determined under the following chart, based on which event (from events (a) through (e) above) has occurred:

Event	**Event type**	**Applicable Event Date**
(a)	Initial COBRA election	First day of 60-day COBRA election period
(b)	Initial COBRA payment	First day of 45-day initial payment period
	Monthly COBRA payment	First day of 30-day payment grace period
(c)	COBRA qualifying event notice	First day of 60-day period for providing notice
(d)	Initial claim	Date of claim
(e)	Internal appeal	Date of receipt of claim denial

PLAN INFORMATION

1. The Plan Sponsor and Plan Administrator is Syracuse City School District.

2. The Plan Sponsor's and Plan Administrator's Address is 725 Harrison Street, Syracuse, New York 13210

3. The Plan sponsor's EIN is 15-6010157

4. The Plan Sponsor and Plan Administrator's phone number is 315-435-4171

5. The Plan is a cafeteria plan under section 125 of the Internal Revenue Code. The Health FSA Benefit under the Plan is a welfare benefit plan.

6. The Plan number is 510.

7. The Plan's designated agent for service of legal process is the Plan Sponsor. Any legal papers should be delivered to the Plan Sponsor at the address listed above. However, service may also be made upon the Plan Administrator.

8. The Plan Year is the 12-consecutive month period ending on December 31.

9. Amount contributed by Plan Participants and the Company to the Plan are general assets of the Company. All payments of benefits under the Plan are made solely out of the general assets of the Company. The Company has no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. The Company may, in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.