BROOME-DELAWARE-TIOGA BOCES
FLEXIBLE SPENDING PLAN

SUMMARY PLAN DESCRIPTION
FOR 1995
(amended 1998)
(amended 4-2006)

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BROOME-DELAWARE-TIOGA BOCES

FLEXIBLE SPENDING PLAN

INTRODUCTION

We are pleased to announce that we have established a Flexible Spending Plan (Plan) for you and other eligible employees. Under this Plan, you will be able to choose among certain benefits that we make available. The benefits that you may choose are outlined in this Summary Plan Description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you can join and the laws that protect your rights.

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

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed as you enroll in the Plan and while you are a participant. You should direct any questions you have to the Plan Administrator. (See the Article entitled "General Information About Our Plan" for information about your Plan Administrator). There is a Plan Document on file which you may review, if you desire. In the event there is a conflict between this Summary Plan Description and the Plan Document, the Plan Document will control. Also, if there is a conflict between an insurance contract and either the Plan Document or this Summary Plan Description, the insurance contract will control.

I
ELIGIBILITY

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

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

2. What Are the Eligibility Requirements for Our Plan?

   All regular full time non-represented employees and all employees represented by a bargaining unit, who are continuously so employed by BOCES for at least one full year.

3. When Is My Entry Date?

   The entry date for eligible employees will be the first day of the next Plan Year.

4. Are There Any Employees Who Are Not Eligible?

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

(a) employees who are not eligible to receive medical benefits under our group medical plan
(b) certain non-resident aliens whose income is not considered income earned within the United States under federal tax laws
(c) former employees

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

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

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

II
OPERATION

How Does This Plan Operate?

Before the start of each Plan Year, you will be able to elect to have your employer apply some of your upcoming pay to provide benefits. Your employer will maintain recordkeeping accounts in order to pay for the benefits you have chosen. The portion of your pay that is paid to the Plan for benefits is not subject to Federal income or withholding tax or to Social Security or Medicare or to state income taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled, "General Information About Our Plan" for the definition of Plan Year.)

III
CONTRIBUTIONS

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

Each year, you may elect to have us contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from

your pay each pay period on a pro rata basis over the course of the year. However, you may not have us contribute more than your annual gross salary per Plan Year. The minimum participation for the Health Care Account is $200 annually and the maximum for the Health Care Account is $2,000 annually.

2. How Is My Compensation Measured Under Our Plan?

Compensation under our Plan means the total cash amount that is paid to you each year.

3. What Happens to Contributions Made to the Plan?

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

4. When Must I Decide Which Benefits I Want to Use?

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

5. When Is the Election Period for Our Plan?

When you first meet the eligibility requirements, your election period will start on that date and run to your entry date, and continue for 30 days past your entry date. (You should review Section I on Eligibility to better understand the terms eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Plan Administrator and applied uniformly to all participants. The election period will normally be a period of time prior to the beginning of each Plan Year. The Plan Administrator will inform you each year about the election period.

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

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change if there is a change in your status which affect eligibility of employee, spouse or dependent. Currently, federal law considers the following events to be changes in status:

(a) changes to legal marital status which include marriage, divorce, separation, annulment or death of a spouse
(b) a change in the number of dependents, such as birth, death, adoption, or placement for adoption
(c) changes in the employment status of the participant or of the participant's spouse or dependents including commencement or termination of employment (except in the

case of the employee's termination of employment), a strike or lockout, the commencement or ending of an unpaid leave of absence, a change in work site, or a change in employment status which affects eligibility under the Plan

(d) a dependent becoming eligible or ceasing to be eligible for coverage due to age, student status, or any similar circumstance

(e) a change in residence of the participant or the participant's spouse or dependents

(f) the employee, spouse or dependent becoming eligible or ceasing to be eligible for Medicare or Medicaid

(g) significant change in cost (increase or decrease) of a qualified benefit
Cost changes do not affect the Unreimbursed Medical Expense Account under any circumstance. The Dependent Care Expense Account, cannot be increased if the provider is a relative of the participant.

(h) changes in coverage
If coverage is significantly curtailed, except in regard to the Unreimbursed Medical Expense Account, the participant may revoke elections for the benefit or make a new election on a prospective basis for coverage under another providers benefit package providing similar coverage.

If you have a change in status, you should contact the Administrator within 30 days of the event which causes the change in status. Your Administrator will provide you with the required forms for changing your benefit elections.

In addition, for health insurance premiums being automatically contributed to the Plan, we will adjust the salary redirection election you have made for the remainder of the Plan Year if there is a change in the premium expense. If the increase in premium expense is significant, we will let you either change the salary redirection election or revoke your election entirely. However, you will only be able to revoke your election in this situation if we provide another health plan with similar coverage which you agree to participate in or you can provide proof of alternative coverage. If no other health plan exists, no revocation will be permitted.

Consistency Requirement

An election change must be consistent with the circumstances and conditions of the claimed change in status. A change in status that affects eligibility under the Plan includes a change that results in an increase or decrease in numbers or dependents who may benefit from coverage under the Plan.

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

Yes, you may. For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. New elections must be made during the election period prior to the beginning of each Plan Year.

IV
BENEFITS

What Benefits Are Available?

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

Employer-sponsored Medical Insurance Plan
Unreimbursed Medical Expense Account
Dependant Care Expense Account
Cash Benefit

Employer-sponsored Medical Insurance Plan:

Your employer offers medical insurance coverage to all eligible participants. Your employer pays a portion of the premiums for such coverage and deducts the required participant contribution from the participant's paycheck. Your employer will, automatically, deduct from the participant on a pre-tax basis, salary reductions in the amount equal to the participant's current share of premiums for this coverage. If an employee wishes not to have his/her salary reduced by these amounts or does not wish to have these premiums redirected from his/her salary on a pre-tax basis, he/she must complete a declination form which can be obtained from his/her employer.

Your employer has the right to select suitable health and hospitalization insurance contracts in providing this benefit. The medical insurance plan chosen must provide, among other benefits, for at least 48 hours of in-hospital post-partum maternity and newborn care for a normal vaginal delivery and not less than 96 hours following a cesarean section. In addition, the plan chosen must provide mental health benefits. These insurance contracts control the conditions of coverage and the rights of the participants. Descriptions of conditions and rights regarding insurance coverage may be obtained from the Plan Administrator without cost.

With respect to the medical insurance, an employee may exercise his/her right to opt out of coverage in accordance with the following:

BSSA - BOCES Support Services Association & Confidentials

An employee has the right to elect coverage in the Program for him/herself and his/her family, if eligible. If the employee elects to withdraw from, or not to join such Program, he/she will not be eligible for any benefits from such Program, with the sole exception of prescription drug coverage and/or dental which he/she may elect to maintain by separate application. The District will not, in any way, be responsible for any health insurance obligations as a result of withdrawing from, or declining the Program.

An employee will not be eligible to rejoin the Program until one year following declination/withdrawal.

In consideration for waiving the right to health insurance coverage, an employee will be paid $150 (individual plan eligibility) or $450 (family plan eligibility), and shall be paid on or about December 15th (or within 90 days of coverage cancellation, whichever is later).

*An employee will **NOT** be allowed to rejoin the plan within one year, under any circumstances. If an employee resigns within three months of cancellation of coverage, the amount of payment received by the employee will be due back to the District.*

"It is the responsibility of the employee to complete an application before the beginning of the new insurance plan year should he/she decide to subscribe to the Program."

BMA - BOCES Management Association

An employee has the right to elect coverage in the Program for him/herself and his/her family, if eligible. If the employee elects to withdraw from, or not to join such Program, he/she will not be eligible for any benefits from such Program, with the sole exception of prescription drug coverage and/or dental which he/she may elect to maintain by separate application. The District will not, in any way, be responsible for any health insurance obligations as a result of withdrawing from, or declining the Program.

Following declination/withdrawal, an employee will not be eligible to rejoin the Program except during re-enrollment time.

In consideration for waiving the right to health insurance coverage, an employee will be paid $150 (individual plan eligibility) or $450 (family plan eligibility), and shall be paid on or about December 15th (or within 90 days of coverage cancellation, whichever is later).

*An employee will **NOT** be allowed to rejoin the plan within one year, under any circumstances. If an employee resigns within three months of cancellation of coverage, the amount of payment received by the employee will be due back to the District.*

"It is the responsibility of the employee to complete an application before the beginning of the new insurance plan year should he/she decide to subscribe to the Program."

BTA - BOCES Teachers Association

An employee has the right to elect coverage in the Program for him/herself and his/her family, if eligible. If the employee elects to withdraw from, or not to join such Program, he/she will not be eligible for any benefits from such Program, with the sole exception of prescription drug coverage and/or dental which he/she may elect to maintain by separate application. The District will not, in any way, be responsible for any health insurance obligations as a result of withdrawing from, or declining the Program.

An employee will not be eligible to rejoin the Program until one year following declination/withdrawal.

In consideration for waiving the right to health insurance coverage, an employee will be paid $150 (individual plan eligibility) or $450 (family plan eligibility), and shall be paid on or about December 15th (or within 90 days of coverage cancellation, whichever is later).

*I have been advised that I will **NOT** be allowed to rejoin the plan within one year, under any circumstances. If I resign within three months of cancellation of coverage, the amount of payment received by me will be due back to the District.*

"It is the responsibility of the employee to complete an application before the beginning of the new insurance plan year should he/she decide to subscribe to the Program."

DPEA

An employee has the right to elect coverage in the Program for him/herself and his/her family, if eligible. If the employee elects to withdraw from, or not to join such Program, he/she will not be eligible for any benefits from such Program, with the sole exception of prescription drug coverage and/or dental which he/she may elect to maintain by separate application. The District will not, in any way, be responsible for any health insurance obligations as a result of withdrawing from, or declining the Program.

Once coverage is declined, coverage may only be activated during the (next re-enrollment time) semi-annual reopening periods of the policy. (Currently, the month of September for effective date of insurance October 1 and the month of March for the effective date of insurance October 1 and the month of March for the effective date of March 1 each year.)

DECLINATION OF INSURANCE COVERAGE

AFTER CAREFULLY REVIEWING YOURS AND YOUR DEPENDENTS NEEDS, YOU MAY DECLINE ENROLLMENT IN THE FOLLOWING INSURANCE COVERAGE:

HEALTH INSURANCE, INCLUDING PRESCRIPTION PLAN, INDIVIDUAL COVERAGE FOR SELF.	Individual $225	Individual Dependent $225
HEALTH INSURANCE, INCLUDING PRESCRIPTION PLAN, DEPENDENT COVERAGE.	N/A	$350
DENTAL INSURANCE, INCLUDING PRESCRIPTION PLAN, INDIVIDUAL COVERAGE FOR SELF.	$15	$15
DENTAL INSURANCE, INCLUDING PRESCRIPTION PLAN, DEPENDENT COVERAGE.	N/A	$35
HEALTH INSURANCE, (INDIVIDUAL COVERAGE FOR SELF), PARTICIPANT IS NOT COVERED BY PRESCRIPTION PLAN.	$150	$150
HEALTH INSURANCE, (FAMILY COVERAGE), PARTICIPANT IS NOT COVERED BY PRESCRIPTION PLAN FOR DEPENDENTS	N/A	$300

Unreimbursed Medical Expense Account:

The Unreimbursed Medical Expense Account enables you to pay for expenses which are not covered by our insured medical plan and save taxes at the same time. The account allows you to be reimbursed by the employer for out-of-pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify, normally are those permitted by Section 213 of the Internal Revenue Code. You may not, however, be reimbursed for the cost of any health care premium nor spousal health care premiums maintained by the spouse's employer. In addition, you may redirect a maximum of $2,000 to this Plan.

In order to be reimbursed for a health care expense, you must submit to the third party administrator an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. Reimbursement shall be paid at least once a month.

Dependent Care Expense Account:

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

An eligible dependent is any member of your household who has the same place of abode as you for more than one half of such taxable year for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care expense arrangements which qualify include:

(a) dependent (day) care center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws

(b) an educational institution for pre-school children: for older children, only expenses for non-school care are eligible

(c) an individual who provides care inside or outside your home: the individual may not be a child of yours under age 19 or anyone who you claim as a dependent for federal tax purposes

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Expense Account. Currently, that amount is $5,000.00 per year or $2,500.00 if you are married and filing tax returns separately. Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred.

In addition, federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Expense Account under our Plan. Ask your tax adviser which is better for you.

Cash Benefit:

Any eligible employee who does not wish to participate in any of the benefit options or does not elect any salary redirections, then such employee shall be deemed to have chosen the cash benefit or the wages due less all mandatory withholdings, as his/her sole benefit option. This means that the employee has elected to receive all compensation ordinarily due without any deductions save mandatory withholding taxes and Social Security.

V
BENEFIT PAYMENTS

1. When Will I Receive Payments From My Plan?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered incurred when the service is performed, not necessarily when it is paid for. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the Plan has agreed to pay for, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the Plan are generally not subject to Federal income tax or withholding, nor are they subject to Social Security taxes, state, city or local withholding taxes. Requests for payment of insured benefits should be made directly to the insurer.

The provisions of the insurance policies will control what benefits will be paid and when. You will only be reimbursed from the Dependent Care Expense Account to the extent that there are sufficient funds credited to the account to cover your request.

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

Any monies left at the end of the Plan Year will be forfeited. Obviously, qualifying expenses that you incur late in the Plan Year for which you seek reimbursement after the end of such Plan Year will be paid first before any amount is forfeited. However, you must make your requests for reimbursement no later than 90 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. What Happens If I Terminate Employment?

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

(a) insurance coverage remains
Insurance coverage remains only for the period for which premiums have been paid prior to your termination of employment.

(b) reimbursement may be requested for qualifying Dependent Care Expense Account expenses incurred during the Plan Year, if other requirements are met
No further salary redirection contributions will be made on your behalf after you terminate.

(c) contributions to the Unreimbursed Medical Expense Account will stop
You will have 90 days after your termination of employment to request reimbursement for expenses incurred prior to your separation from service, unless you choose to continue paying the amounts that would have been withheld if you were still working with after-tax dollars under the COBRA rules explained below.

Under a federal law, referred to as COBRA, you, your spouse, and your dependents may be entitled to continuation of health care coverage. This means coverage in effect for medical insurance and the coverage you elected in the Unreimbursed Medical Expense Account. The Plan Administrator will inform you of these rights if you terminate employment. Your rights are summarized below.

(a) For purposes of COBRA, a qualified beneficiary is the participant or any covered spouse or dependent child (family member) who has a right to continue health coverage under COBRA when a qualifying event occurs. (A child who is born to or being placed for adoption with you during a period of COBRA coverage is also considered a qualified beneficiary.)

(b) A participant has a right to choose health continuation coverage under COBRA for the participant and covered family members if health coverage under the Plan is lost because of reduction in hours of employment or termination of employment (for reasons other than gross misconduct on the participant's part). For this and all other provisions of this section, the health coverage that may be continued is the coverage in effect when a qualifying event occurs; namely an elected health benefit and/or any coverage elected under the Unreimbursed Medical Expense Account.

Continuation of Coverage:

In the case of an elected health benefit and/or any coverage elected under the Unreimbursed Medical Expense Account, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among the types of coverage (i.e. single, family, etc.).

Type of Coverage:

Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

Coverage Period:

The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

(a) in the case of a terminated employee (except for gross misconduct) or a covered employee whose hours have been reduced, except as provided in (b) and (c) below, and his/her covered dependents, the date which is 18 months after the qualifying event

(b) in the case of a qualified beneficiary disabled during the first 60 days following the covered employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event

(c) in the case of a qualifying event which occurs during the 18 months after the date that a covered employee is terminated (except for gross misconduct) or the date that a covered employee's hours are reduced, for the covered dependents, the date which is 36 months after the date that a covered employee is terminated (except for gross misconduct), or the date that a covered employee's hours are reduced

(d) (1) for plan years commencing on or prior to June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered employee and that employee's subsequent entitlement to Medicare while continuation coverage is in force for the qualified beneficiary, the date which is 36 months after the date of the covered employee's entitlement to Medicare

(2) for plan years commencing after June 30, 1997, in the case of a termination (except for gross misconduct) or reduction in hours of a covered employee that occurs less than 18 months before the covered employee becomes subject to Medicare, the date which is the close of the 36-month period beginning on the date the covered employee became entitled to Medicare

(e) in the case of any qualifying event except as described in (a), (b), (c) and (d) above, the date which is 36 months after the date of the qualifying event

(f) the date on which the employer ceases to provide any group health plan to any employee

(g) the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision

(h) the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or

otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event will coverage continue longer than the coverage period as set forth below under the heading of Contribution.

Contribution:

(a) A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the employer in full and in advance, except as provided in (b) below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments.

(b) Except as provided in (c) below, the payment of any premium shall be considered to be timely if made within 30 days after the date due or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) and (b) above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

Notification by Qualified Beneficiary:

Each covered employee or qualified beneficiary must notify the employer of the occurrence of a divorce or legal separation of the covered employee from such covered employee's spouse, and/or the covered employee's dependent child ceasing to be a dependent child under the terms of this Plan within 60 days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph which occur after the date of the enactment of the Tax Reform Act of 1986.

Notification to Qualified Beneficiary:

(a) The employer shall provide written notice to each covered employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.

(b) The employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered employee from the covered employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, the employer shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered employee or the qualified beneficiary notifies the employer of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986, within 60 days after the date of such qualifying event. If a covered employee or qualified beneficiary has not been adequately informed of the obligation to provide notice in the case of a qualifying

event, that is the divorce or legal separation of the covered employee or that is a dependent child ceasing to be covered under the generally applicable requirements of the Plan, the covered employee's or qualified beneficiary's failure to provide timely notice to the Plan Administrator will not affect the Plan's obligation to make continuation coverage available upon receiving notice of such event.

(c) Notification of the requirements of this provision to the spouse of a covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

4. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be reduced slightly because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf. The reduction often will be very small. However, the impact will vary from case to case and cannot be predicted by the employer.

5. What Happens If I Take an Unpaid Leave Under FMLA or USERRA?

If you take an unpaid leave of absence under The Family Medical Leave Act (FMLA) and want to continue in the Plan you may do so by making the required contributions under the group health insurance plan (if applicable) and the Unreimbursed Medical Flexible Spending Account. If you wish you may pre-pay your contributions before you take your leave; pay-as-you-go during the period with after-tax dollars; or you may take the catch-up option which allows you to make up payments after you return to work. The manner in which payments are made will be determined by your Plan Administrator.

If you take a leave under The Uniformed Services Employment and Reemployment Act (USERRA) you may continue under health coverage for a maximum of 24 months and under the Unreimbursed Medical Account until the end of the Plan Year or, under either coverage, until you fail to apply for reinstatement or return to employment with the employer, whichever occurs first. Should you elect to continue coverage under USERRA, you will have access to the full annual amount budgeted and, you will be required to make contributions under the Plan using one of the following three alternatives:

(a) pre-tax salary redirection of full amount prior to leaving active employment
(b) payment while on active duty with after-tax dollars
(c) payment after return of employment with pre-tax dollars

Your right to continuation of coverage under USERRA runs concurrently with your rights, if any, under COBRA.

Should you elect to terminate coverage, you may continue to draw on any funds remaining in your account until the end of the Plan Year and may be reinstated in the Plan within the Plan Year on the same terms as before you terminated.

Your spouse or covered dependent(s) may be authorized upon presentation of appropriate documentation to the employer, to complete claim forms on your behalf for the duration of your deployment. Checks will however, be made payable in your name only.

VI
HIGHLY COMPENSATED AND KEY EMPLOYEES

Do Limitations Apply to Highly Compensated Employees?

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

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents.

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

VII
PLAN ACCOUNTING

Periodic Statements

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

VIII
GENERAL INFORMATION ABOUT OUR PLAN

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

1. General Plan Information

BROOME-DELAWARE-TIOGA BOCES Flexible Spending Plan is the name of the Plan. Your employer has assigned Plan Number 501 to your Plan.

The provisions of the Plan become effective on April 1, 1995, which is called the Effective Date of the Plan.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The initial Plan Year begins on April 1, 1995 and ends on September 30, 1995. Subsequent Plan Years will begin on October 1 and run through September 30.

2. Plan Sponsor

Your employer is the Plan Sponsor. Your employer's name, address, and identification number are:

TAX ID #15-6008639
BROOME-DELAWARE-TIOGA BOCES
435 GLENWOOD ROAD
BINGHAMTON, NEW YORK 13905-1699

3. Plan Administrator Information

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

BROOME-DELAWARE-TIOGA BOCES
435 GLENWOOD ROAD
BINGHAMTON, NEW YORK 13905-1699
(607) 763-3456

Preferred Group Plans, Inc. is the third party administrator for the Plan. The Administrator keeps the records for the Plan and is responsible for the administration of the Plan. Preferred Group Plans, Inc. will also answer any questions you may have about our Plan. You may contact Preferred Group Plans, Inc. for any further information about the Plan at 1-800-573-7474.

4. Service of Legal Process

The Name and address of the Plan's agent for service of legal process is:

BROOME-DELAWARE-TIOGA BOCES
KAREN MCMAHON
435 GLENWOOD ROAD
BINGHAMTON, NEW YORK 13905-1699
(607) 763-3456

5. Type of Administration

The type of Administration is Employer Administration.

6. Medical Insurance Carrier(s) Information

EXCELLUS BC/BS OF SOUTH TIER REGION
344 SOUTH WARREN STREET
SYRACUSE, NEW YORK
(315) 448-3801

IX
ADDITIONAL PLAN INFORMATION

1. Your Rights Under ERISA:

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

(a) examine, without charge, at the Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and

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

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

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

2. Claims Process

When filing your claim, you must submit proof of each charge. It is extremely important that you secure copies of bills for all charges. All bills should be itemized.

All benefits provided by the Plan will be paid as soon as possible upon receipt of proof of claim. Benefits will be payable to the employee, if living, otherwise to the estate of the employee.

You should submit reimbursement claims during the Plan Year, but in no event later than 90 days after the end of a Plan Year. Any claims submitted after that time will not be considered. Claims for benefits that are insured will be reviewed in accordance with procedures contained in the policies. All other general claims or requests should be directed to the Administrator of our Plan. If your health benefits claim is denied in whole or in part, the Plan Administrator will notify you in writing or electronically of its determination within certain time frames of receipt of claim. The Plan Administrator may determine that more time is needed, but will notify you in writing of such before the end of the respective claim period.

If your claim is not filed properly, you or your authorized representatives will be notified of such and of the procedures to be followed to properly file a claim.

Concurrent care decisions to reduce or terminate ongoing treatment will be communicated in writing or electronically to you far enough in advance to give you time to appeal and obtain a determination on review before the benefit is reduced. Any request that you may make to extend the treatment beyond the Plan-specified time or number of treatments will be decided within 24 hours of the Plan receiving your request to extend treatment at least 24 hours before the scheduled termination or reduction in treatment. Any decision by the Plan will be conveyed to you either in writing or electronically.

Pre-service claims (adverse or not) will be decided within 15 days of receipt. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, but the Plan will notify you in writing or electronically of the circumstances causing the delay and the date a determination is expected. If the delay is due to a faulty claim, this notice of extension of time to decide the claim will describe the specific information you must provide to the Plan. You will have at least 45 days from receipt of the notice to provide the information.

Post-service claims denials will be decided and communicated to you in writing or electronically within 30 days of receipt of the claim. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, in which case the Plan will notify you in writing or electronically within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide you at least 45 days from receipt of the notice to provide the necessary information.

Urgent care claims (adverse or not) will be decided within 72 hours of receipt of the claim or sooner if possible. If the claim is incomplete, so that a determination cannot be made of whether benefits are covered or payable under the Plan, your Plan Administrator will notify you within 24 hours of receipt of the claim, or sooner if possible, of the information needed to complete the claim. You then have 48 hours to provide the information. Once the additional information is received by your Plan Administrator, the claim will be decided within 48 hours of the earlier of:
(1) the Plan's receipt of the specified information; or
(2) the end of the period afforded you to provide the specified additional information.

Notice of Adverse Determinations:

You will be given written or electronic notice of any adverse benefit determination on your claim. The notice will set forth:

(a) the specific reasons for denial;
(b) reference to the specific plan provisions on which the decision is based;
(c) a description of any additional material or information needed for you to perfect the claim and an explanation of why the material or information is needed;
(d) a description of the Plan's review procedures and the applicable time limits, as well as, a statement of your right to sue;
(e) any specific rule, guide line, protocol or other similar criterion the decision-maker relied upon in making the adverse determination, and that a copy of the rule, guideline, etc., will be provided free;
(f) if the decision is based on a medical necessity or experimental treatment or similar limit, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free upon request; and
(g) if the request involves an urgent care decision, a description of the applicable expedited review process.

When an urgent care decision is involved, information may be provided orally initially, but will be provided in writing or electronically within three days of the oral notice.

Claims Appeal Procedures:

Participants and beneficiaries are entitled to appeal an adverse claims decision to the Plan Administrator, and to get a full and fair review.

If you should decide to appeal an adverse determination, you will have 180 days to appeal following receipt of notice of an adverse benefit decision.

You may submit written comments, documents, records and other information relating to the claim.

Pursuant to your appeal, you are entitled to receive free, upon request, access to and copies of all documents, records and other information relevant to the claim.

You also will receive a review that takes into account all comments, documents, records and other claim-related information. The review will be conducted by a Plan fiduciary that is neither the individual who made the initial denial or the subordinate of such individual.

If your claim was denied in whole or in part based on a medical judgment, the fiduciary will consult with a health care professional who will neither be an individual who was consulted in connection with the initial decision, nor the subordinate of any such individual.

You will be provided the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan regardless of whether the advice was relied on to make the initial decision.

In the case of urgent care, you will be provided expedited review upon your request whether you make such a request orally or in writing.

All necessary information may be transmitted between you and the Plan by phone, fax or other expeditious means.

Review of Denied Claims:

Following your health claim appeal, the Plan Administrator will review, make a determination on that appeal and communicate its decision to you or your representative as described below.

Urgent care claims. Decisions on review of urgent care appeals will be made and communicated to you within 72 hours of receipt of the request for review.

Pre-service claims. Decisions on review of pre-service claims will be made and communicated as soon as reasonable but not later than 30 days after receipt of the request for review.

Post-service claims. Decisions on review of post-service claims will be made and communicated as soon as reasonable, but not later than 60 days after receipt of the request for review.

Notice of Determination:

Any decisions on your appealed claim will be communicated to you or your representative in writing or electronically. In the notice, you will be provided:

(a) the specific reasons for the determination;
(b) a reference to specific plan provisions on which the decision was based;
(c) a statement informing you of your rights to receive, upon request and free, access to and copies of all documents, records and other information relevant to the claims; and

(d) a description of any additional, voluntary appeal procedures (if any) the Plan offers and of your right to obtain information about the procedures.

If the determination was made based on an internal rule, guideline or other protocol of the Plan, you will be provided the specific rule, guideline, protocol or other criterion relied on, or you will receive a statement that such rule, guideline protocol or other criterion is available free upon request.

If the basis of the Plan's denial of your appealed claim is on medical necessity, experimental treatment or other similar exclusion or limit, you will receive either:

(a) an explanation of the scientific or clinical judgment in applying the Plan terms to your medical circumstances; or
(b) a statement that such an explanation will be provided free upon request.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

3. Qualified Medical Child Support Orders

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a Qualified Medical Child Support Order (QMCSO). Basically, a QMCSO is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an alternate recipient to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An alternate recipient is any child of a participant who is recognized by a medical child support order as having a right to enrollment under a participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

X
SUMMARY

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

If you have any questions, please contact the Plan Administrator.

APPENDIX A

Standards for Privacy of Individual Identifiable Health Information (the "Privacy Standards")
issued pursuant to
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Preferred Group (PG) Notice of Privacy Practices

HIPAA Provisions

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan. (See the Article entitled "General Information About Our Plan" for the definition of Plan Sponsor.)

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards)

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI

(c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards

(d) Report to the Plan any PHI use or disclosure that is inconstant with the uses or disclosures provided for of which the Plan Sponsor becomes aware

(e) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524)

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526)

(g) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528)

(h) Make its internal practices, books and records relating to the use and disclosure of

PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*

(i) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible

(j) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Human Resources Manager
Staff designated by Human Resources Manager
Chief Financial Officer
Plan Auditor
Plan Administrator
Third Party Administrator

ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Plan Administration activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. Plan Administration functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans. The plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate

the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with Privacy Standards.

The Preferred Group (PG) Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At PG, we believe in keeping your protected health information (PHI) safe. PHI includes information that we have created or received about your past, present, or future health or medical condition that could be used to identify you. It includes information about medical treatment you have received and about payment for health care you have received. PG keeps protected health information in strict confidence. As part of providing services, we may get information from the following sources: application forms, claims, and other information provided to us. This information can be given to us in writing, in person, by telephone, or by any other means. This information may include name, address, and employment information. We do not share, sell, or rent any protected health information about our current or former members.

PG restricts access to information to those PG employees who need to know that information to provide services. We also maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your information.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures PG will make of your protected health information. This notice takes effect on April 14, 2003. PG reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. If we make significant changes to the privacy practices on this notice, we will send a new Notice of Privacy Practices to all plan participants within 60 days. You can always request a copy of our most current privacy notice from our office or you can access it on our Web site at www.thepreferredgroup.com.

Permitted Uses and Disclosures

PG can use or disclose your protected health information for purposes of treatment, payment and health care operations. Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used. When the plan receives a bill from you or the provider, PG can obtain information regarding your care, if necessary, to provide payment. Health care operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, provider reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of providers used in our plan. We may also combine medical information about many patients to decide how to better provide needed benefits under the plan.

Other Uses and Disclosures of Protected Health Information

PG may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you. PG may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. PG will only disclose the protected health information directly relevant to their involvement in your care or payment. PG may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, or payment for that care. If you are available, PG will give you an opportunity to object to these disclosures, and the plan will not make these disclosures if you object. If you are not available, PG will determine whether a disclosure to your family or friends is in your best interest, and the plan will disclose only the protected health information that is directly relevant to their involvement in your care or payment for that care.

Except for the situations set forth below, PG will not use or disclose your protected health information for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing except to the extent that PG already has taken action in reliance on your authorization.

Exceptional Situations
We may use or disclose your protected health information in the following situations without your authorization:

We may release medical information to: a coroner or medical examiner (for example, to identify a deceased person); federal or state agencies that oversee our activities (to monitor the health care system, government programs, and compliance with other laws.); to a correctional institution or a law enforcement official (to protect your health and safety or the health and safety of others); to a law enforcement official (in response to a court order, subpoena, warrant, summons or similar process); to a court (in response to a subpoena, discovery request, or other lawful process); to military command authorities (if you are a member of the armed forces); to authorized federal officials for intelligence or other national security activities; to an organ donation organization (to facilitate organ or tissue donation and transplantation); to authorized federal officials (to provide protection to the President or other authorized persons); to public health agencies (to prevent or control disease, injury or disability); to appropriate agencies (to prevent or lessen a serious and imminent threat to the health or safety of a person or the public) and to programs that provide benefits for work-related injuries or illness.

Your Rights
- You have the right to request restrictions on PG's uses and disclosures of protected health information for treatment, payment and health care operations. However, PG is not required to agree to your request.
- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations. (*Use: Alternate Means of Communication Request Form*)
- Subject to payment of a reasonable copying charge (if you cannot afford to pay for copies, you will not be denied access), you have the right to inspect and copy the protected health information contained in the plan's records, except for psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. (*Use: Inspection and Copying Request Form*)
- You have the right to request a correction to your protected health information, but PG may deny your request for correction. Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records. (*Use: Amendment of Health Information Form*)
- You have the right to get a list of situations in which we have given out your PHI. The list will <u>not</u> include: a) disclosures we made so you could get treatment; b) disclosures we made so we could make payment for your treatment; c) disclosures we made in order to operate our business; d) disclosures made directly to you or to people you choose; e) disclosures made to corrections or law enforcement personnel; f) disclosures we made before we sent you this notice; or g) disclosures we made when we had your authorization. We will respond within 60 days of getting your written request for the list. The list we give you can only include disclosures made after April 14, 2003, the date this notice becomes effective. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. (*Use: Accounting of Disclosures Request Form*)
- You have the right to request and receive a paper copy of this notice from us.

Filing a Complaint
If you believe that your privacy rights have been violated, you should immediately contact Julie Salisbury at 800-573-7474 . PG will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Contact Person
If you have any questions or would like further information about this notice, please contact Arlene J. Tamasi at 800-573-7474. This notice is effective as of April 14, 2003.

APPENDIX B

Flexible Spending Plan Reimbursement Voucher

How To Complete Reimbursement Voucher

Election Change Form (Due to Change In Status)

Termination From Service Election Form