N.Y.C. HEAD START MANAGEMENT WELFARE FUND EMPLOYEE MEDICAL REIMBURSEMENT PROGRAM

SUMMARY PLAN DESCRIPTION
(EFFECTIVE AS OF JANUARY 1, 2013)

N.Y.C. HEAD START MANAGEMENT WELFARE FUND
EMPLOYEE MEDICAL REIMBURSEMENT PROGRAM

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1. THE EMPLOYEE MEDICAL REIMBURSEMENT PROGRAM

The insured health plan offered by the District Council 1707 Head Start Employee's Welfare Fund ("Health Plan") pays a portion of your health care costs. However, there are a number of health-related expenses which you must pay yourself. You are responsible for satisfying the annual deductibles and for co-insurance payments out of your own pocket. You may also have expenses, such as those for dental care or vision care, that may not be covered under the Health Plan.

The N.Y.C. Head Start Management Welfare Fund Employee Medical Reimbursement Program (referred to as the "Employee Medical Reimbursement Program" or "Program") provides you with the opportunity to use tax-free dollars allocated to an "account" established for you to reimburse you for certain expenses not covered under the Health Plan. The Program was effective July 1, 1996.

This booklet constitutes the summary plan description for the Employee Medical Reimbursement Program as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA) and reflects the provisions of the Program as in effect as of January 1, 2013. This booklet, along with the Trust Agreement and Administrative Guide constitute the Program and are incorporated herein by reference.

2. WHO IS ELIGIBLE

You and your "Qualified Dependents" (see definition below) are eligible to participate in the Employee Medical Reimbursement Program if you are a management or other non-union employee of an " Eligible Agency" following the completion of 30 days of full-time paid employment and enrollment in the Health Plan. Prior full-time paid service you had with a Head Start Agency, other than your current employer, will count towards the 30 day employment requirement, but it will be solely your responsibility to inform your current employer of such service and to provide proof of such employment. An "Eligible Agency" includes delegate N.Y.C. Early Learn Agencies that sponsor a Head Start program as well as direct (federal) funded Head Start Agencies, provided that the agency is a member of the Head Start Sponsoring Board Council and is enrolled in the Health Plan.

For purposes of the Program, "Qualified Dependents" include:

- your spouse;
- your children (married or unmarried) up until the end of the month in which they attain age 26;
- your unmarried children over age 26 if they are mentally or physically incapable of self support, and they qualify as dependents on your Federal tax return. Proof of the child's condition must be submitted for a handicapped child over age 26.

Children include natural and/or legally adopted children and step children, as well as foster children and grandchildren for whom the court has issued you legal guardianship. In the case of divorce, this includes children for whom a court has issued you a Qualified Medical

Child Support Order (QMCSO) which has been approved as meeting the legal standards in force for QMCOs.

3. ENROLLMENT DATE

You become a participant in the Employee Medical Reimbursement Program on the first day of the month following the completion of the 30 days service requirement provided the Fund has received your completed enrollment form. You are automatically enrolled in the Program when you enroll in the Health Plan.

4. CONTRIBUTIONS

The Employee Medical Reimbursement Program is funded by contributions made by your employer. You are neither required nor permitted to make contributions to the Program. Each January 1 the Trustees of the New York City Management Welfare Fund (the "Trustees") will determine the amount of contributions that will be allocated to each Program participant's account. For the Program Year beginning January 1, 2013 and ending December 31, 2013, $800 will be allocated to each Program participant's account. Please note that the Trustees have the discretion to increase, decrease, suspend or terminate the annual allocation.

If you become a participant in the Program on a date other than January 1, the amount of contributions allocated to your account will be prorated depending on the number of full calendar months remaining in the year. For example, if you become a participant in the Program on April 1, 2013, your allocation for 2013 will be $600 ($800 x 9/12). Eligible administrative expenses are paid by the Plan.

5. ABOUT YOUR ACCOUNT

As indicated, contributions received from your employer will be allocated into a special account that can be used throughout the year to reimburse you for certain out-of-pocket health care expenses. As you incur "eligible expenses" during the year and pay for them out of your own pocket, you reimburse yourself from your account with tax-free dollars (up to the amount allocated to your account for the year).

6. ELIGIBLE EXPENSES

Any medical care expenses that the IRS considers to be deductible for tax purposes (Internal Revenue Code §213) and that are not covered by the Health Plan, other insurance or any other accident or health Plan, are eligible for reimbursement from your account. Eligible medical, dental, vision or hearing expenses must meet the following criteria:

- Expenses are for "medical care" including diagnosis, cure, mitigation, treatment, or prevention of illness or injury; transportation cost of a trip primarily for and essential to medical care; or for medical insurance;
- Expenses are not for cosmetic surgery or cosmetic dentistry undertaken to only approve appearance;

- Expenses are incurred by you, your spouse and your eligible children (as defined by IRS rules);
- Expenses are not reimbursed by any insurance carrier.
- Expenses are for medical care or services performed in the Program Year (not when billed or paid);
- Expenses are not being claimed as a medical deduction on the participant's or dependent's federal tax return;
- Expenses are not for vitamins (unless prescribed by a Doctor);
- Expenses are not for over-the-counter dietary supplements, cosmetics or toiletries that promote wellness and/or are beneficial to general good health or hygiene (glucosamine, calcium, zinc, suntan lotions, toothpaste, face creams);
- Expenses are not for over-the-counter medicines other than insulin.

Examples of eligible expenses are:

MEDICAL

Deductibles

Co-payments

Expenses in excess of covered amounts

Routine physicals (not covered by any health insurance)

Prescription drugs not covered by your insurance carrier

Transportation costs related to trips to and from the health care provider

Medical insurance; premiums that are not paid on a pre-tax basis

Certain over-the-counter medicines if prescribed by a licensed Health Care Provider

DENTAL

Deductibles

Co-payments

Expenses in excess of covered amounts or plan limits or not otherwise covered by your insurance carrier

VISION

Examinations

Frames and prescription lenses

Prescription contact lenses, maintenance solutions and equipment

HEARING

Examinations

Hearing aids and equipment (batteries, etc.)

You may wish to obtain IRS Publication 502, "Medical and Dental Expenses," from your local IRS office or the Trustees for an overview of eligible expenses. If you have any questions as to whether a particular service or product is eligible for reimbursement under the Program please call Healthplex the Fund's third party administrator, at (800) 468-0608 or (516) 542-2200.

7. SUBMITTING CLAIMS FOR ELIGIBLE EXPENSES

Generally, you should submit claims to all benefit plans under which you, your spouse or your children) are covered (i.e., the Health Plan or your spouse's company-sponsored plan) before you request reimbursement under the Employee Medical Reimbursement Program. Healthplex, Inc. has been retained by the Trustees as the Program's third-party administrator.

Contributions allocated to your account for each Program Year may only be used to reimburse you for Eligible Expenses that you incur during the "Period of Coverage" (see Section 8).

In order to receive reimbursement for your eligible health care expenses, you will need to submit a claim form, along with proper documentation of the expense, to:

NYC Head Start Management Welfare Fund
Employee Medical Reimbursement Program
c/oHealthplex, Inc.
60 Charles Lindbergh Blvd.
Uniondale, New York 11553

Claim forms are available from your Director or Human Resources and from Healthplex, Inc.

For Eligible Expenses payable by another benefit plan, you should attach a copy of the Explanation of Benefits (EOB) statements) from that other plan to the claim form for this Program. For expenses not covered by another benefit plan, you should attach a copy of the

paid, itemized receipt to your claim form. If only a portion of an Eligible Expense has been reimbursed elsewhere (e.g., because Health Plan imposes copayment or deductible limitation) the Program can reimburse the remaining portion of such Eligible Expense. Please note that canceled checks alone are not sufficient as evidence of expenses incurred.

Claims for benefits under the Program will be processed monthly by Healthplex, Inc. However, payment for claims received by Healthplex after the 15th of the month may not be made until the last week of the following month.

At any given time during a Program Year you can be reimbursed for Eligible Expenses up to the annual amount allocated to your account, less prior reimbursements for the same Program Year, with one exception. Each claim must contain sufficient expenses so that the amount of the reimbursement requested totals at least $50. Claims for Eligible Expenses totaling less than $50, will be held by Healthplex, Inc. until: (a) the expenses submitted total at least $50; (b) your account would be zeroed out by payment of a lesser amount; or (c) the Period of Coverage ends.

You Have Until the First Day of June to Submit Claims

You may submit reimbursement requests until June 1 of the following year for expenses incurred during the previous year's Period of Coverage. In order to qualify for reimbursement, the Eligible Expense must have been incurred when you were a participant. An expense is incurred on the date the services which resulted in the expense were provided, not the date when you receive the bill or pay the expense. For example, if you incurred an eligible expense in December 2013 but you are billed for it in April 2014, it is an eligible expense for the 2013 Program Year and you have until the June 1, 2014 to submit your claim for reimbursement.

PLEASE KEEP IN MIND THAT YOU'RE BEING REIMBURSED FOR YOUR EXPENSES -- IT IS YOUR RESPONSIBILITY TO PAY THE BILL ON TIME.

8. FORFEITURE OF ACCOUNTS

Forfeitures

The amount credited to you for each Program Year must be used for reimbursement of Eligible Expenses incurred during a "Period of Coverage." The "Period of Coverage" is the Program Year plus a 2½ month grace period following the close of the Program Year (March 15). The claims submission period ends on the June 1st immediately following the close of the Period of Coverage. If there is a balance remaining in your account after all reimbursements, the balance will be forfeited.

Unused dollars cannot be given to you, nor may you carry over your account balance from one Period of Coverage to the next Period of Coverage. For example, if $800 is allocated to your account for 2013 and you incur only $400 of reimbursable claims by March 15, 2014, you will forfeit the remaining $400.

In addition, any Program reimbursements that are unclaimed (e.g. uncashed benefit checks) by the end of the Period of Coverage following the Period of Coverage in which the

Medical Care Expenses were incurred shall be forfeited. For example, the reimbursement check issued for expenses incurred on December 30, 2013 (during the Period of Coverage that ends March 15, 2014) must be cashed no later than March 15, 2015.

Tax Effect for Certain Employees

If you are a highly compensated employee (as the term is defined by the IRS), the reimbursements you receive from the Program may be taxable to you if the Program is considered discriminatory under IRS rules. The Trustees have the authority to make adjustments to the operation of the Program if necessary or appropriate to meet such nondiscrimination requirements. You will be notified if this restriction applies to you.

Changes in the Law

The Employee Medical Reimbursement Program allows employees certain tax advantages based upon current tax laws. These laws and, therefore, the Program, are subject to change. You'll be notified if a change in the law requires us to make a change in the way the Program works.

9. IF YOU TERMINATE PARTICIPATION OR EMPLOYMENT

If you are no longer a full-time paid management or other nonunion employee of an Eligible Agency or your employment terminates, your participation in the Employee Medical Reimbursement Program will cease. Eligible Expenses incurred after the date your participation terminates will not be eligible for reimbursement.

However, you may continue to request reimbursement until June 1st of the following year for Eligible Expenses incurred prior to your termination. Unused money remaining in your account will be forfeited, unless you submit a claim for reimbursement of Eligible Expenses prior to the close of the claims submission period mentioned above.

However, when your participation in the Program would otherwise cease as described above, you, your spouse and your dependents may be entitled to continue your coverage in the Program pursuant to COBRA. See Section 10 below for further details on your COBRA continuation rights.

10. COBRA CONTINUATION COVERAGE

Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you, your spouse and your covered dependents may be entitled to continue coverage under the Program after coverage would otherwise terminate.

You, your spouse and your covered dependents will be entitled to COBRA continuation coverage if your coverage in the Program terminates for any of the reasons set forth below:

- **Termination of Employment or Reduction in Hours:** If the loss of coverage is a result of the termination of your employment (other than for gross misconduct) or reduction in your hours of employment you and your spouse and/or dependent

children may elect COBRA continuation coverage for up to 18 months. This 18 month continuation period can be extended in two circumstances:

- First, if an individual electing COBRA continuation coverage is determined under the Social Security Act to have been disabled at any time within the first 60 days of COBRA continuation coverage, the 18-month period is extended for up to an additional 11 months (for a total of up to 29 months). This 11-month extension of COBRA continuation coverage is only available if the disabled individual notifies the Trustees of the determination of Social Security disability within 60 days of the determination and before the 18-month period expires. Non-disabled family members (who are receiving COBRA continuation coverage) of a disabled individual who is receiving continuation coverage are also eligible for 29 months of COBRA Continuation Coverage.

- Second, the 18-month continuation period for your spouse and/or dependent children may be extended an additional 18 months (for a total of up to 36) months) if, during the 18-month period, you die, you and your non-employee spouse divorce or legally separate, or you become entitled to Medicare. Also, the 18-month continuation period for a dependent child may be extended to 36 months if, during the 18-month period, the dependent child ceases to be eligible for coverage as a dependent.

o **Divorce or Legal Separation:** If you and your spouse divorce, or are legally **separated,** your non-employee spouse and dependent children may be eligible to elect COBRA continuation coverage for up to 36 months.

o **Death:** If you die, your non-employee spouse and dependent children may elect COBRA continuation coverage for up to 36 months.

o **Dependent Children:** If your children cease to be eligible for coverage as dependents pursuant to the terms of the Head Start Medical Plan, your children may elect COBRA continuation coverage for up to 36 months.

o **Medicare Entitlement:** If you become entitled to Medicare, your non-employee spouse and dependent children may elect COBRA continuation coverage.

Eligibility, Notification Requirements and Election of COBRA Continuation Coverage

If any of the special circumstances described above occur, you, your spouse and dependent children may elect COBRA continuation coverage provided:

o Each person electing COBRA continuation coverage was covered by the Program or their medical expenses were subject to reimbursement on the day prior to the date on which the termination of employment, reduction in hours, divorce or legal separation, death, loss of dependent status, or Medicare entitlement occurred.

- You, your spouse, or your dependent children notify the Trustees of a divorce, legal separation or loss of a child's dependent status within 60 days of the date on which the divorce, 'legal separation or loss of a child's dependent status occurred.

- You, your covered spouse, and/or your dependent children elect COBRA continuation coverage within 60 days after the later of: (i) the date coverage is lost due to any of the events specified above; or (ii) the date the Trustee provides written notice of the right to elect COBRA continuation coverage. Your spouse and dependent children may elect COBRA continuation coverage even if you decide not to.

Cost of COBRA Continuation Coverage

You, your spouse or your dependent children will be required to pay the full cost of coverage plus an administrative fee (not to exceed 2% of the cost of coverage). The first premium payment (which includes all premium payments owed from the date your coverage would otherwise have terminated) is due within 45 days following your election of COBRA continuation coverage. The grace period for the payment of all premiums due thereafter is 30 days. The cost of coverage may change from year to year but in general each month's cost will equal the amount allocated to active participants' accounts divided by 12 (plus the 2% administrative fee). If you qualify for the 11-month extension due to Social Security disability, you will be required to pay 150% of the cost of coverage (plus the 2% administrative fee), as permitted by law.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will stop sooner than the periods described above if-

- you, your spouse or your dependents fail to make the required payments on a timely basis. If you fail to pay before the applicable grace period expires, coverage will be terminated retroactive to the last day for which payment was received;

- you, your spouse or your dependents become covered under another employer's group health plan which does not contain any exclusion or limitation with respect to any pre-existing; condition of such person;

- you, your spouse, or your dependents become entitled to Medicare (however, if you become entitled to Medicare, your spouse and your dependents can continue COBRA continuation coverage for up to the 36 month limit);

- the Program is terminated and the Program sponsor no longer provides group health coverage to any of its employees; or

- an individual receiving the 11-month extension to the 18-month COBRA continuation period for a Social Security disability determination is subsequently determined to be no longer disabled under the Social Security Act. The individual is required to notify the Trustees of that determination within 30 days.

IF YOU HAVE QUESTIONS

Questions concerning the Program or your COBRA continuation rights should be addressed to the Program Administrator. (See Section 16). For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA) and other laws affecting group health plans contact the nearest Regional or District office of the U.S. Department of Labor's Employer Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone number of Regional and District EBSA offices are available through the EBSA's website.

11. FMLA AND USERRA

The Employee Medical Reimbursement Program provides certain additional rights to Program participants who go on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA") or the Uniformed Services Employment and Reemployment Rights Act of 1994 (the "USERRA"). Please contact the Plan's Administrator if you need additional information.

12. PROCEDURE FOR APPEALING CLAIMS

When you file a claim for a benefit under the Program, you will generally be notified whether the claim is approved or denied within 30 days of receipt of the claim. In some circumstances, however, you may be notified before the end of the first 30 day period that the response period has been extended for up to an additional 15 days. If an extension is required the notice will inform you of the special circumstances that require an extension and will also indicate the date by which the Program expects to make a determination. If more time is needed because information is missing from your claim request, the notice will describe what information is still needed and you or your representative must provide this additional information within 45 days of your receipt of the notice. The period for determining your claim will be suspended on the date the Program sends the notice of missing information and will resume on the date you or your representative responds to the notice.

If your claim is denied in whole or in part, the notification you receive will provide:

- the specific reasons for the adverse determination;
- specific reference to the pertinent provisions of the Employee Medical Reimbursement Program documents on which the decision was based;
- a description of any additional information or materials needed to further process the claim, including an explanation of why such information or materials are necessary;
- an explanation of the steps you can take to have the adverse determination reviewed and the applicable time limits, including a statement of your rights to bring civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; and

- upon request and free of charge, a copy of any internal rules, guideline, protocol or other criterion that was relied upon in making the adverse determination regarding your claim and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion limit.

13. APPEALS PROCEDURE

If your claim is denied and you would like to appeal the denial of your claim, you must submit a request in writing within 180 days of receiving notification of denial. You should include in your request for appeal why you think your appeal should be approved and include any information, documents and records supporting your appeal.

You may request from Healthplex, Inc., at no charge, reasonable access to and copies of all documents and records relevant to your appeal.

The review will take into account all of the information you have submitted including comments, documents and records, whether or not such information was submitted or considered in the initial claims determination.

Your appeal will be reviewed by someone who was not involved in the initial denial of your claim. (Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional with training and experience in the appropriate field(s) of medicine under consideration).

You will be notified, in writing, of the decision on your appeal not later than 60 days after the Program received your request for a review. If more information is needed to make a determination, we will notify you in writing prior to the end of the 60 day period to specify any additional information needed to complete the review.

A notice of an adverse determination on your appeal will include:

- the specific reason or reasons for the adverse determination;
- reference to the specific Program provision including any internal rules, guidelines and protocols on which the decision was based (a copy of such internal rules, guidelines and protocols are available upon request free of charge);
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other relevant information without regard to whether such documents and records were considered or relied upon in deciding the appeal (including the identities of and reports by any experts whose advice was obtained).
- the written notice will also contain a statement of the claimant's right to bring civil action under ERISA Section 502(a) after all administrative remedies under this Program have been exhausted.

If you are not satisfied with the decision on appeal, you or the Program 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. You may also contact Healthplex, Inc. or the Trustees.

14. YOUR RIGHTS UNDER ERISA

As a participant in the Program you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Program participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, (such as worksites) all documents governing the Program and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Program, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Program's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Program as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Program on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Program, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Program Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Program, called "fiduciaries" of the Program, have a duty to do so prudently and in the interest of you and other Program participants and beneficiaries. No one, including your

employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

In your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Program documents or the latest annual report from the Program and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan 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 after you have exhausted all administrative remedies under the Program. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after you have exhausted all administrative remedies under the Program. If it should happen that Program fiduciaries misuse the Program'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.

Assistance with Your Questions

If you have any questions about your Program, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contract the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

15. Privacy of Your Medical Information

The Program operates in accordance with regulations under the Health Insurance Portability and Accountability Act as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to Protected Health Information or Electronic Protected Health Information (together "PHI") as that term is defined in HIPAA. For purposes of the Program, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information, that relates to your or their eligibility for benefits under the Program.

Permitted Uses and Disclosures of PHI by the Program and the Program Sponsor

The Program and the Program Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general Program administration, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.

- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Program.

- Other uses relating to Program administration which are approved in writing by the Program Administrator.

- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Program.

Uses and Disclosures of PHI by the Program
and the Program Sponsor for Required Purposes

The Program and Program Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.

- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

- As otherwise may be required by law.

Sharing of PHI With the Program Sponsor

As a condition of the Program Sponsor receiving PHI from the Program, the Program Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Program documents in Sections I and II above;

- Ensure that any agents or subcontractors to whom it provides PHI received from the Program agree to the same restrictions and conditions that apply to the Program Sponsor;

- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Program Sponsor;

- Report to the Program any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

- Make PHI available to Program participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Program available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Program that the sponsor still maintains in any form and retain no copies of such information 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 the information infeasible;

- Ensure that adequate separation between the Program and Program Sponsor is established in accordance with the following requirements:

Restriction to Program Administration Functions: The access to and use of PHI by the employees of the Program Sponsor designated above will be limited to Program administration functions that the Program Sponsor performs for the Program.

Security Measures for Electronic Protected Health Information. The Program Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of a Covered Individual's Electronic PHI that the Program Sponsor creates, receives, maintains or transmits on the Plan's behalf.

Notification of Security Incident. The Program Sponsor will report to the Program any attempted or successful unauthorized access, use , disclosure, modification or destruction of information or interference with systems operations in the Program Sponsor's information systems, of which the Program Sponsor becomes aware.

16. GENERAL INFORMATION

If you file a claim or request for information, you may need the information listed below.

Program Name

N.Y.C. Head Start Management Welfare Fund
Employee Medical Reimbursement Program

Program Sponsor

Head Start Sponsoring Board Council of the City of New York, Inc.
1120 Avenue of the Americas, Suite 4110
New York, NY 10036
(212) 626-2644

Employer Identification Number

13-3794644

Program Number

503

Program Year

January 1 to December 31

Program Type

The Employee Medical Reimbursement Program is a Health Reimbursement Arrangement and (as covered by sections 105 of the Internal Revenue Code). Such plans are not insured by the Pension Benefit Guaranty Corporation.

Program Administrator

The Employee Medical Reimbursement Program is administered by the Trustees of the New York City Head Start Management Welfare Fund. The Trustees are Andre Lake, Cynthia Cummings and Gina Rusch.

The Program Administrator makes the rules and regulations necessary to administer the Program. The Program Administrator shall have the discretionary authority and responsibility to determine eligibility for Program benefits and the amount of such benefits, and to construe the terms of the Program. The Program Administrator's determinations and constructions will be final, binding and conclusive as to all parties, unless found to be arbitrary and capricious by a court of competent jurisdiction.

You may contact the Program Administrator by writing to:

Trustees of the New York City Head Start Management Welfare Fund
c/o Randy Paul
D.C. 1707, Local 95 AFSCME AFL-CIO
Head Start Employees Welfare Fund
420 West 45th Street, 3rd Floor
New York, NY 10036

You may also call Randy Paul at (212) 343-1660

Claims processing under the Program and questions concerning claims in progress are handled by:

Healthplex, Inc.
60 Charles Lindbergh Blvd.
Uniondale, New York 11553

(800) 468-0608 or (516) 542-2200

Appeals of claims which are denied in whole or in part under the Program are handled by the Program Administrator.

Agent for Service of Legal Process

Legal process may be served on the Program Administrator.

Program Continuance

The Trustees of the New York City Head Start Management Welfare Fund reserve the right to amend or terminate the Program at any time without prior notice or approval. The right to amend includes, but is not limited to, the following:

- the right to curtail or eliminate coverage for any care, treatment, procedure, or service irrespective of whether any participant or other person entitled to benefits under the Program is receiving such treatment for an injury, defect, illness, or disease contracted prior to the effective date of the amendment; and

- the right to adopt employee contributions, and the right to adopt or lower caps on individual covered benefits.

Any such amendment or suspension may apply to all or any portion of the Program and to all participants and beneficiaries under the Program or to only a portion of the participants and beneficiaries under the Program.

Cost of Program

The entire cost of benefits; under the Program is paid for by Early Learn agencies through employer contributions and by employees through after-tax COBRA contributions.

Nonguarantee of Employment

Participation in the Program does not confer to you any rights of continued employment. Your employer reserves the right to terminate your employment at its discretion.