GREAT NECK UNION FREE SCHOOL DISTRICT'S FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Amendment and Restatement
Effective as of July 1, 2003

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Great Neck Union Free School District's Flexible Benefits Plan (the "Plan"). We urge you to read this summary carefully.

This summary is the "Summary Plan Description" for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Great Neck Union Free School District (the "District") and are available to you for inspection at a time and place mutually agreeable to you and to the District.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator identified at the end of this Summary Plan Description or contact Fitzharris & Co., Inc., which provides contract administration, recordkeeping and claims processing services for the Plan on behalf of the Plan Administrator, at 1-800-321-1336, or write Fitzharris & Co., Inc. at 814 Fulton Street, Farmingdale, NY 11735.

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TABLE OF CONTENTS

GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

Great Neck Union Free School District's Flexible Benefits Plan

Name and Business Address of District

Great Neck Union Free School District
345 Lakeville Road
Great Neck, New York, 11020

Type of Administration

The Plan is administered by the Plan Administrator. The Plan Administrator has contracted with Fitzharris & Co., Inc. to provide certain recordkeeping, claim processing and other administrative services on their behalf. Please note that participant benefit accounts under the Plan merely are bookkeeping entries, that no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the District's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Plan Year

Effective as of July 1, 2003, the Plan Year is the period beginning each January 1 and ending each December 31 during which the Plan is in effect. Prior to July 1, 2003, the Plan Year was the period beginning each July 1 and ending each June 30 during which the Plan was in effect. The Plan experiences a short Plan Year from July 1, 2003 to December 31, 2003.

Name, Business Address and Telephone Number of Plan Administrator

Great Neck Union Free School District
345 Lakeville Road
Great Neck, New York, 11020
(516) 773-1452

Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Name, Business Address and Telephone Number of Plan Recordkeeper

Fitzharris & Co., Inc.
814 Fulton Street
Farmingdale, New York 11735
1-800-321-3215 (for claim inquiries and submission)

Type of Plan

This Plan is a form of employee welfare benefit plan called a "cafeteria plan" because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the District to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. Because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan.

Eligibility

If you are a regular contractual employee of the District (as determined by the District), you and your eligible dependents are eligible to participate in the Plan (other than the health care or dependent care flexible spending features of the Plan) beginning on the first day of active employment (unless you are hired during July or August to begin actively working in September, in which case you and your eligible dependents are eligible to participate in the Plan (other than the health care or dependent care flexible spending features of the Plan) on the September 1st following your date of hire) (your "Participation Date"). Notwithstanding the preceding, no employee is eligible to begin participation in the health care or dependent care flexible spending account provisions of the Plan prior to the January 1st coinciding with or next following the employee's date of hire (or, if later, January 1, 2004).

Please note that persons classified by the District as temporary employees of the District (as determined by the District) are not permitted to participate in the Plan. A person who is not characterized by the District as an employee of the District, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the District.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit.

For Plan purposes, an eligible dependent is an individual who is: (a) the spouse of a Plan participant; (b) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support; (c) an unmarried child of a Plan participant if the child is age 19 or over, but under age 25, a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, and primarily dependent on the participant for support; (d) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child's age, provided such mental or physical condition commenced prior to the attainment by the child of age 19, or age 25 if the child was age 19 or over and enrolled as a full-time student at the date of such commencement; (e) any child of a participant who does not qualify as a dependent under

subsections (b), (c) or (d) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement; (f) any other individual who is a dependent of the Plan participant described in ' 152(a) of the Code and whose welfare is the legal responsibility of the Plan participant pursuant to a legal guardianship, written divorce settlement, written separation agreement or a court order.

For purposes of the preceding paragraph, the word "child" includes natural children, legally adopted children who are under age 18 at the time of the adoption, children placed for adoption (provided the child is under age 18 at the time of the placement), foster children (provided the foster child is not a ward of the state) and stepchildren who depend on the Participant for support. In addition, a spouse or child will not qualify as an eligible dependent if such spouse or child is on active duty in the armed forces of any country or if such spouse or child is an employee of the Employer.

Any pre-existing condition exclusions do not apply to an adopted child of an eligible employee, or a child placed for adoption with an eligible employee, if the child is under 18 years of age at the time of the adoption or placement for adoption, and if the eligible employee is eligible for Plan coverage at the date of the adoption or placement.

A person otherwise qualifying as an eligible dependent will not be covered for any coverage providing benefits to dependents unless the participant has elected to pay and has paid the required additional contributions, if any, for dependent coverage.

Participation

You may become a participant on your Participation Date, provided you properly submit an Election Form to the Plan Administrator prior to that date and during the period designated by the Plan Administrator as your initial "enrollment period" and provided the District determines you have the status of an active employee of the District on your Participation Date. You will be treated as an active employee on that date even if you are absent from work if your absence occurs because of a health condition (as determined by the District).

(a) Election Form: Initial Election Period. You must properly complete and submit an initial Election Form to the Plan Administrator prior to your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period" in order to begin participation in the Plan on your Participation Date. With respect to any election to be covered under the medical/prescription drug coverage provisions of the Plan, your benefit election made on the initial Election Form will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you or your dependents experience a Status Change (see subsection (d) below), exercise a Special Enrollment Period right (see subsection (g) below) or qualify to change your elections for certain other reasons (see subsections (e) and (f) below). With respect to any election to be covered under any other (i.e., non-medical/prescription drug) coverage provisions of the Plan, your benefit elections made on the initial Election Form will be effective from your Participation Date until the last day of the Plan Year in which falls your Participation Date. Your election generally is irrevocable during the initial election period, unless you or your dependents experience a Status Change (see subsection (d) below), exercise a Special Enrollment Period right (see subsection (g) below) or qualify to change your elections for certain other reasons (see subsections (e) and (f) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during the initial election period, you will not participate automatically in any other feature of the Plan.

(b) Election Periods After Initial Election Period For Medical/Prescription Drug Coverage. After you complete the initial Election Form, your initial benefit election with respect to medical/prescription drug coverage will remain in effect indefinitely or until you or your dependents experience a Status Change (see subsection (d) below), exercise a Special Enrollment Period right (see subsection (g) below) or qualify to change your medical/prescription drug elections for certain other reasons (as described in subsections (e) and (f) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator for a future Plan Year during the period preceding the Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your new medical/prescription drug benefit election will be effective from the first day of the Plan Year following the election period in which you make your new benefit election until you change your election during a later election period, or you experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan.

(c) Annual Election Periods After Initial Election Period For All Other Coverages. After you complete the initial Election Form, in order to continue coverage under the non-medical/prescription drug coverage provisions of the Plan, you must complete and submit an Election Form to the Plan Administrator for each new Plan Year during the period preceding such Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your election will be effective for the next Plan Year and is irrevocable unless you or your dependents experience a Status Change (see subsection (d) below), exercise a Special Enrollment Period right (see subsection (g) below) or qualify to change your elections for certain other reasons (see subsections (e) and (f) below). If you fail to complete and submit a new Election Form, you will not participate automatically in any non-medical/prescription drug coverage provision of the Plan for the next Plan Year unless you exercise a Special Enrollment Period right.

(d) Changes of Election to Reflect Status Change. Within 30 days after a Status Change, you may, with the approval of the Plan Administrator and subject to conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form, provided that the change you make to your elections is consistent with the Status Change.

The District will determine whether, under applicable law, a requested change is consistent with the Status Change you experience. For example, if you become eligible for health insurance sponsored by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the District that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective, in the case of non-medical/prescription drug coverages, for

the balance of the Plan Year in which the new election is made or, in the case of non-medical/prescription drug coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

If you fail to properly complete and submit an Election Form to the Plan Administrator during the initial election period, you will not participate automatically in the Plan.

You will be deemed to have a Status Change if:

(1) your marital status changes through marriage, the death of your spouse, divorce, legal separation or annulment;

(2) there is an event which causes you to gain or lose a dependent;

(3) you, your spouse or your dependent terminates or begins employment;

(4) there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;

(5) you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);

(6) an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage under the Plan due to attainment of age, student status, or similar circumstance;

(7) there is a change in location of the residence or worksite of you or your spouse or other dependent;

(8) for purposes of dependent care assistance benefits, there is an event that changes the number of your dependents who are under the age of 13 or mentally or physically incapacitated.

Under applicable law, to be permitted to make a change of election relating to your coverage for a benefit due to a Status Change (among other requirements) the Status Change must result in you or your spouse or dependent gaining or losing eligibility for that coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent. For benefits that provide dependent care assistance, you are also permitted to make an election change if a Status Change increases or decreases your dependent care expenses and the election change corresponds to the change in expenses.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within a reasonable time after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective, in the case of non-medical/prescription drug coverages, for the balance of the Plan Year in which the new election is made or, in the case of medical/prescription drug coverage, until you change your elections according to the Section entitled "Election Periods After Initial Election Period".

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

(i) Significant Cost Changes. If the cost that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the cost that you are required to pay for a benefit option significantly decreases (as determined by the District) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

Ordinarily, you may change the amount you contribute to a dependent care flexible spending account because of a significant increase or decrease in cost. However, under applicable law, if the dependent care provider who is imposing the increased cost is a close relative of yours, you cannot change your election. For this purpose, a close relative includes your parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

You may change your elections because of a significant cost change, as described above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the District or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Coverage Changes. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the District).

If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the District), and the significant curtailment amounts to a complete loss of coverage (as determined by the District), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual or lifetime

limit. The District, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

If the District adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the District), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes that your spouse or a dependent makes to his or her benefit elections under a benefit plan offered by his or her employer. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's annual election period, you may change your benefit elections to correspond to the changes elected by your spouse during his or her employer's annual election period. Also, if your spouse's employer has a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and your spouse makes one of those permitted changes, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made by your spouse. For example, if your spouse revokes his or her benefit election for a health plan offered by her employer because of the increase in cost, you could change your election under a health plan offered by this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

The rights described in paragraphs (i) through (iv) above do not apply to elections involving a health care flexible spending account. You may not change the amount you contribute to a health care flexible spending account because of an change in cost or a change in coverage of another benefit option and you may not make an election change for any other benefit option because of a change in the cost or coverage under your health care flexible spending account or the health care flexible spending account of your spouse or dependent.

(e) Other Election Changes. If you are entitled to an election change described below, you must request the change within a reasonable time after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, subject to the District's approval, the Plan administrator may change your health coverage election if the Plan is required by the order to provide such coverage and may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the District that such coverage is actually being provided, subject to the District's approval, you will be permitted to change your election to stop providing medical coverage for your child.

If you or your spouse or dependent becomes eligible for Medicare or Medicaid, subject to the District's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the District's approval, you may change your election to commence or increase medical coverage for that individual.

Finally, if you take leave under the Family and Medical Leave Act of 1993 ("FMLA"), you may make certain election changes that are permitted by the District in accordance with the FMLA.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the medical coverage feature(s) of this Plan, provided that you request enrollment within 30 days after your other coverage ends. If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be given the opportunity to provide details concerning your situation on a form provided by the Administrator if the Administrator requires you to do so in order to preserve your special enrollment rights under the Plan in the future. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the medical coverage feature(s) of this Plan, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Termination of Participation

Coverage for a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment.

(b) Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the District or a participant.

(c) With respect to any coverage requiring participant contributions and with respect to which participant contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an District.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment.

(b) Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the District or a participant.

(c) With respect to any coverage requiring participant contributions and with respect to which participant contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by the District.

(f) The day on which the eligible dependent ceases to be an eligible dependent.

Regardless of any provision described above, if you take a leave of absence from employment with the District because of military service, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for you and your covered spouse or dependents. You will be required to pay for such coverage in an amount determined under USERRA. Such coverage will end on the earlier of: (1) the last day of the 18-month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the District. Please contact the Employer if you have questions about coverage during periods of military service.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect or require an alteration of your elections or benefits, you will be notified.

(a) Medical/Prescription Drug and Dental Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug coverage (unless you elect to waive that coverage and instead receive a cash bonus, as per your bargaining agreement) and dental coverage. A detailed description of this coverage appears in the Benefits Booklets. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the District, and will be communicated to you from time to time.

(b) Health Care Flexible Spending Account (Effective January 1, 2004). If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $2,500 per Plan Year (or such other amount per Plan Year determined by the District and communicated to you in writing), credited to your Health Care Flexible Spending Account. You can receive amounts from this Account, in cash, as reimbursement for health-related medical expenses (as defined in the Plan) incurred during the Plan Year. Generally, health-related medical expenses are those which are not covered under any plan or employer-provided medical coverage, meet the Internal Revenue Code's definition of deductible medical expenses, and have not been taken as a deduction in any tax year.

Please be aware, however, that amounts held in your Health Care Flexible Spending Account for which a request for reimbursement has not been received by the 90th day following the close of the Plan Year will be forfeited. If you separate from service with the District while you are a participant in the Health Care Flexible Spending Account, you may, under applicable law, be permitted to continue participating in the Account.

If you wish to be reimbursed from your Health Care Flexible Spending Account, you must submit to the Recordkeeper a request for such reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit such requests by the 90th day following the earlier of (1) the close of the Plan Year for which the benefit election is effective or (2) the date your participation in the Health Care Flexible Spending Account ends.

(c) Dependent Care Flexible Spending Account (Effective January 1, 2004). If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $5,000 per calendar year or, in the case of married participants filing separately, $2,500 per calendar year, credited to your Dependent Care Flexible Spending Account. You can receive amounts from this Account, in cash, as reimbursement for Employment Related Expenses (as defined in the Plan) incurred during the Plan Year. However, the amount of any reimbursement for Employment Related Expenses may not exceed the amount credited to your Account at the time of your reimbursement request. Generally, Employment Related Expenses are expenses for household services and expenses related to the care of a dependent who is under the age of 13, or a spouse or dependent who is mentally or physically incapacitated, which are incurred to enable you to work.

Please be aware that the amount of reimbursements that you may receive from your Dependent Care Flexible Spending Account on a tax-free basis in a Plan Year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. Thus, for example, if you have $5,000 in your Dependent Care Flexible Spending Account and you and your spouse have Earned Income of $20,000 and $4,000, respectively, you can receive $4,000 worth of reimbursement from the Account on a tax-free basis, and you will be taxed on $1,000 worth of the reimbursement you receive.

Also, you should note that amounts held in your Dependent Care Flexible Spending Account for which a request for reimbursement has not been received by the 90th day following the close of the Plan Year will be forfeited. If you have amounts credited to your Dependent Care Flexible Spending Account and you separate from service with the Employer, you may continue to receive reimbursements from the Account for eligible expenses incurred during the Plan Year, but you may not continue to contribute to the Account.

If you wish to be reimbursed from your Dependent Care Flexible Spending Account, you must submit a reimbursement request to the Plan Recordkeeper on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Plan Administrator. You must submit such requests by the 90th day following the close of the Plan Year.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts which you exclude from income under the Dependent Care Flexible Spending Account will reduce, dollar for dollar, the tax credit available.

Attached as an Exhibit is a notice which further explains the dependent care tax credits and the income exclusions. The notice also provides a worksheet to help you determine which tax reduction method is more beneficial for you.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator. Also, please review the next section regarding continuation coverage under the Federal law known as "COBRA".

Continuation Coverage Under COBRA

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end.

If you are an employee of the District and covered by the Plan, you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee and you are covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for *any* of the following four reasons:

(1) The death of your spouse;

(2) A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with the Employer;

(3) Divorce or legal separation from your spouse;

(4) Your spouse becomes entitled to (that is, covered by) Medicare.

In the case of a covered dependent child of an employee, he or she has the right to choose continuation coverage if group health coverage under the Plan is lost for *any* of the following five reasons:

(1) The death of the employee;

(2) The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment with the Employer;

(3) The employee's divorce or legal separation;

(4) The employee becomes entitled to (that is, covered by) Medicare;

(5) The dependent ceases to be a "dependent child" under the Plan.

Under the law, the employee or a family member has the responsibility to inform the Employer of a divorce, of a legal separation, or of a child losing dependent status under the Plan, within 60 days of the event. Failure to meet this requirement results in loss of continuation coverage rights. The Employer has the responsibility to notify the Recordkeeper or insurer of the employee's death, termination, reduction in hours of employment, or Medicare entitlement. (Similar rights may apply to certain retirees, spouses, and dependent children if the Employer commences a bankruptcy proceeding and these individuals lose coverage.)

When the Recordkeeper or Employer is notified that one of these events has happened, the Recordkeeper or Employer will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Recordkeeper or Employer that you want continuation coverage.

If you do not choose continuation coverage, your group health coverage will end.

If you choose continuation coverage, the District is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is generally 18 months. This 18 months may be extended for affected individuals to 36 months from the termination or reduction in hours of employment if other events (i.e., the employee's death, divorce, legal separation, or Medicare entitlement) occur during the original 18 month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made an individual eligible to elect coverage.

The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) as of the termination or reduction in hours of employment (or during the 60 day period thereafter). To benefit from this extension, you must notify the Recordkeeper or insurer of that determination within 60 days of the date of the determination and before the end of the original 18 month period. The affected individual also must notify the Recordkeeper and Employer within 30 days of any final determination that the individual is no longer disabled.

The law provides that your continuation coverage will be cut short for any of the following five reasons:

(1) The District no longer provides group health coverage to any of its employees;

(2) The premium for your continuation coverage is not paid on time;

(3) After the date of your continuation coverage election, you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have;

(4) You become entitled to (that is, covered by) Medicare after you elect COBRA; or

(5) You extended coverage for up to 29 months due to disability and, while you are in the 11 month extension period, there is a final determination that the disabled individual is no longer disabled.

Children born to, or placed for adoption with, a covered employee during a continuation coverage period also have the right to elect COBRA continuation coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you must pay all of the cost of your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the 18, 29, or 36 month continuation coverage period, you are allowed to enroll in an individual conversion health plan if otherwise provided under the Plan.

If there are any changes to your marital status, your or your spouse's address(es), or the dependent status of any of your children under the Plan, please notify the Plan Administrator immediately.

Please note that this is a summary of a very complicated federal law. In the event of any inconsistency between this summary and federal law, federal law will control.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Claims Procedure

In order to receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you.

If a request for Plan benefits is denied, a Plan participant, a beneficiary or a duly authorized representative of either may file a claim for Plan benefits to which the claimant believes he or she is entitled. The claim must be in writing and must be delivered or mailed to the Recordkeeper (or insurer, if applicable).

The Recordkeeper (or insurer, if applicable) must notify the claimant in writing of its decision to grant or deny a claim, in whole or in part, usually within ninety (90) days after receiving the claim. If, due to special circumstances, the Recordkeeper (or insurer, if applicable) needs additional time to process a claim, the claimant will be notified in writing, within ninety (90) days after the Recordkeeper (or insurer, if applicable) receives the claim, of those special circumstances and of when the Recordkeeper expects to make its decision. Under no circumstances may the Recordkeeper (or insurer, if applicable) extend the time for making its decision beyond one hundred eighty (180) days after receiving a claim.

If, within ninety (90) days after filing a claim, the Recordkeeper (or insurer, if applicable) does not furnish the claimant with a notice of its decision or a notice that special circumstances require more time for processing the claim, the claimant may act as though the claim has been denied and may request a review of the denial of the claim.

If the Recordkeeper (or insurer, if applicable) denies a claim, it must provide to the claimant, in writing:

(1) The specific reasons for denial;

(2) A reference to the Plan provision or insurance contract provision upon which denial is based;

(3) A description of any additional information or material that the claimant must provide in order to perfect the claim;

(4) An explanation of why additional material or information is necessary; and

(5) Notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of the claim denial.

A request for review of a denied claim must be made in writing to the Recordkeeper (or insurer, if applicable) within sixty (60) days after receiving notice of denial. As part of the review procedure, the claimant has the right to review pertinent documents and to submit to the Recordkeeper (or insurer, if applicable) in writing issues and comments. The decision upon review will be made within sixty (60) days after the Recordkeeper's (or insurer's, if applicable) receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than one hundred twenty (120) days after receipt of a request for review. The Recordkeeper (or insurer, if applicable) will give the claimant, in writing, a notice of (1) its decision, (2) the specific reasons for the decision, and (3) the relevant Plan provisions or insurance contract provisions on which its decision is based. If the decision is not furnished within that time, the claim will be considered denied upon review. The decision of the Recordkeeper (or insurer, if applicable) will be final and binding upon both parties.

With respect to any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Recordkeeper has been rendered (or deemed rendered).

Termination or Amendment of Plan

The District expects to maintain the Plan indefinitely as a permanent program of employee benefits. However, the District has the right, in its sole discretion, to terminate or amend or amend any provision of the Plan at any time. In the event of the dissolution, merger, consolidation or reorganization of the District, the Plan automatically will terminate unless it is continued by the successor to the District.

Participants in the Plan (including retirees, if any) have no Plan benefits after a Plan termination or a partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial termination and except as otherwise expressly provided, in writing, by the District.

No Continued Employment

No provisions of the Plan or this Summary shall give any employee any rights of continued employment with the District or shall in any way prohibit changes in the terms of employment of any employee covered by the Plan.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets, as interpreted by the Plan Administrator in its discretion, control all coordination of benefits situations involving the Plan and other payors.

Subrogation/Right of Reimbursement

As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverages, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverages to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

Further Information

If you have further questions regarding the Plan or this Summary Plan Description, please contact either the Recordkeeper, Fitzharris & Co., Inc. at 1-800-321-1336 or the Plan Administrator, at (516) 773-1452. Copies of all Plan documents are on file with the Plan Administrator and, upon reasonable request, are available to participants and their beneficiaries for examination during regular business hours.

EXHIBIT: Dependent Care Tax Credit vs. Income Exclusion
(EFFECTIVE BEGINNING JANUARY 1, 2003)

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (which is a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income. This worksheet will help you decide which is better for you.

DEPENDENT CARE TAX CREDIT

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of (1) your actual qualifying dependent care expense or (2) $3,000 if you have one dependent or $6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year. The following chart will help you determine your percentage.

IF YOUR ADJUSTED GROSS INCOME IS		The Percentage Of The Cost Of Dependent Care You Can Deduct From Your Taxes Is
OVER	TO	
$0	$15,000	35%
$15,000	$17,000	34%
$17,000	$19,000	33%
$19,000	$21,000	32%
$21,000	$23,000	31%
$23,000	$25,000	30%
$25,000	$27,000	29%
$27,000	$29,000	28%
$29,000	$31,000	27%
$31,000	$33,000	26%
$33,000	$35,000	25%
$35,000	$37,000	24%
$37,000	$39,000	23%
$39,000	$41,000	22%
$41,000	$43,000	21%
$43,000		20%

Example: An employee's adjusted gross income for the year is $30,000 and the employee spends $2,200 each year for day care for one dependent. When you compare $2,200 with the $3,000 allowed for one dependent, the lesser of the two amounts is $2,200. To find the employee's allowable percentage, you use the above chart. Since the employee's adjusted gross income is $30,000, the employee's percentage will be 27%. Therefore, the amount the employee will be able to deduct from his or her taxes will be $2,200 x 27% or $594.

INCOME EXCLUSION

In lieu of the Dependent Care Tax Credit, each year you may elect to have a certain amount taken out of your paycheck before taxes and have it put into your Dependent Care Flexible Spending Account. This amount must be used during the year in order to pay for qualifying dependent care expenses. In other words, you will not have to pay taxes on the amount you put into the Account that will be used to pay your dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the Plan) of less than $5,000, your income exclusion will be limited to the Earned Income of you or your spouse, whichever is less.

Example: The following is an example of an employee's comparison of whether the employee should use the Dependent Care Tax Credit or the Dependent Care Flexible Spending Account. To make the comparison accurate, assume that the amount that the employee spends each year on dependent care is placed into the Dependent Care Flexible Spending Account.

	Using the Tax Credit	Using the Income Exclusion
Adjusted Yearly Gross Income	$30,000.00	$30,000.00
Subtract: Dependent Care Account	(0.00)	(2,200.00)
Taxable Yearly Income	$30,000.00	$27,800.00
Taxes		
Federal (10% for first $6,000; 15% for next $18,500; 27% for remainder)	$4,842.00	$4,248.00
State (7.5%)	2,250.00	2,085.00
Social Security (generally 7.65%)	2,295.00	2,126.70
Total	$9,387.00	$8,459.70
Subtract: Tax Credit (27% of $2,200)	(594.00)	(0.00)
Total Taxes	$8,793.00	$8,459.70

As you can see from this example, this particular hypothetical employee will pay less in taxes if the employee uses the Dependent Care Flexible Spending Account.

CALCULATE YOUR TAX CREDIT

Use the following chart to determine whether you should use the Dependent Care Tax Credit or the Dependent Care Flexible Spending Account. Remember to compare your actual dependent care expenses to $3,000 (for one dependent) or $6,000 (for two or more dependents). Take the lesser amount from this comparison and multiply it by your adjusted gross income percentage from the chart. This will be your tax credit.

	Using the Tax Credit	Using the Income Exclusion
Adjusted Yearly Gross Income	$_____.	$_____.
Subtract: Dependent Care Account	(_____.__)	(_____.__)
Taxable Yearly Income	$_____.	$_____.
Taxes		
Federal* (_____%)	$_____.	$_____.
State* (_____%)	_____.	_____.
Social Security (generally 7.65%)	_____.	_____.
Total	$_____.	$_____.
Subtract: Tax Credit	(_____.__)	(_____.__)
Total Taxes	$_____.	$_____.

* The actual tax rate will vary depending upon your annual income. Estimate your own tax liability 665 or check with your tax consultant.

USE OF BOTH DEPENDENT CARE TAX CREDIT AND INCOME EXCLUSION

You may use both the Dependent Care Tax Credit and the Dependent Care Flexible Spending Account (although not with respect to the same qualifying dependent care expenses.) However, any amounts which you exclude from income under the Dependent Care Flexible Spending Account will reduce, dollar for dollar, the $3,000 or $6,000 Dependent Care Tax Credit figure, whichever is applicable.

Example: An employee's adjusted gross income for the year is $30,000 and the employee spends $2,200 during the year for qualifying day care for one dependent. The employee elects to place $1,000 into a Dependent Care Flexible Spending Account to pay for a portion of the dependent care expenses. When you compare the employee's remaining dependent care expenses of $1,200 with $2,000 ($3,000 - $1,000), the lesser of the two amounts is $1,200. Given the employee's adjusted gross income of $30,000, the employee's percentage from the chart is 27%. Therefore, the amount the employee will be able to deduct from the employee's taxes will be $1,200 x 27% or $324.

ALWAYS DISCUSS THESE ISSUES WITH YOUR TAX ADVISOR.