

TOWN OF BARRINGTON PRE-TAX PREMIUM PLAN

125 MEDICAL PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2001

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INTRODUCTION

This booklet is called a Summary Plan Description (SPD) and is intended to be a brief description of the provisions of the Plan. Inside, you will find an explanation of your rights, obligations and benefits under the Plan.

Please read the description carefully to answer any questions you may have concerning the Plan. If you have questions after reading this booklet, please ask the Plan Administrator. You also have the right to read a copy of the Plan documents which are on file at the Town's office.

NOTE: WE HAVE TRIED OUR BEST TO MAKE THIS A CLEAR AND UNDERSTANDABLE BOOKLET. HOWEVER, IF THERE IS ANY CONFLICT BETWEEN THIS BOOKLET AND THE ACTUAL PLAN DOCUMENT, OR BETWEEN THIS BOOKLET AND FEDERAL LAW, THE PLAN DOCUMENT OR FEDERAL LAW, AS APPROPRIATE, WILL CONTROL. ALSO, IF THERE IS A CONFLICT BETWEEN AN INSURANCE CONTRACT AND EITHER THE PLAN DOCUMENT OR THIS BOOKLET, THE INSURANCE CONTRACT WILL CONTROL. THIS BOOKLET IS NOT INTENDED TO CHANGE OR EXTEND THE PROVISIONS OF THE PLAN.

A. GENERAL INFORMATION ABOUT THE PLAN

The following is some general administrative information concerning the Plan.

PLAN: The name of the Plan is the "Town of Barrington Pre-Tax Premium Plan." Its identification number is 501. The Plan is legally classified as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986. The initial effective date of the Plan was July 1, 1993. The effective date of the most recent revisions is, in general, January 1, 2001.

PLAN ADMINISTRATOR: The Town serves as the Plan Administrator. The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. If you have any questions about the Plan, please contact the Plan Administrator (or delegated representative).

PLAN YEAR: The Plan Year is a period of time for which all of the Plan's records are maintained. The Plan Year of our Plan is the calendar year (January 1 to December 31).

TOWN: The Town of Barrington is sponsor of the Plan. The Plan sponsor's name, address, telephone number, and federal identification number are:

Town of Barrington
Town Hall
283 County Road
Barrington, RI 02806
Telephone: (401) 247-1900
EIN: 05-6000024

B. PARTICIPATION IN THE PLAN

Q1 *HOW DO I BECOME ELIGIBLE TO BECOME A MEMBER OF THE PLAN?*

A1 In order to become a member of the Plan, you must meet the Plan's eligibility requirements (see Q & A 2) and then join the Plan on the appropriate date (see Q & A 3).

Q2 *WHAT ARE THE ELIGIBILITY REQUIREMENTS?*

A2 If you were a member of the Plan prior to January 1, 2001, you will continue to be a member. If you were not a member prior to January 1, 2001, you will be eligible to become a member of the Plan if you are eligible for coverage under the Town's medical plan and/or dental plan.

Q3 *WHEN CAN I JOIN THE PLAN?*

A3 You can join the Plan as of the first day of the payroll period coincident with or next following the date that you meet the eligibility requirements specified above.

Q4 *WHAT MUST I DO TO ENROLL IN THE PLAN?*

A4 You must complete an election form in order to participate in the Plan. The election form authorizes the Town to reduce your salary to pay for your share of the cost of the insurance premiums for the coverage you have elected.

After you have returned a completed election form indicating your participation in the Plan, the Town will start deducting amounts contributed under the Plan on a pre-tax basis. You can expect to see these deductions from your first paycheck following the date you returned your completed election form to the Town or shortly thereafter.

C. OPERATION OF THE PLAN

Q5 *HOW DOES THE PLAN OPERATE?*

A5 Prior to the start of each Plan Year, you will be able to elect to reduce your salary to pay for your share of the cost of the insurance coverage offered by the Town and chosen by you. The portion of your salary that is contributed to the Plan to pay for your share of the medical and/or dental premiums is not subject to Federal income, State income or Social Security taxes. In other words, the Plan allows you to use pre-tax dollars to pay for your medical and/or dental premiums which you otherwise would pay for with after-tax dollars.

D. CONTRIBUTIONS TO THE PLAN

Q6 *HOW MUCH OF MY SALARY MAY THE TOWN REDIRECT?*

A6 Each Plan Year, the Town will automatically contribute on your behalf enough of your salary to pay for your cost of medical and/or dental premiums, provided you have agreed to this deduction. These amounts will be deducted from your salary each pay period on a pro rata basis throughout the Plan Year.

Q7 *HOW IS MY SALARY MEASURED UNDER THE PLAN?*

A7 Salary under the Plan means your total pay from the Town for the Plan Year.

Q8 *WHAT HAPPENS TO CONTRIBUTIONS MADE TO THE PLAN?*

A8 Before the start of each insurance policy year, you may select the benefit options offered under the Plan that you desire. Approximately thirty (30) days before the Plan Year begins, you may elect to pay for your share of the premium expenses with pre-tax dollars by reducing your salary. The contributions deducted from your salary will be used to pay the premiums for your medical and/or dental coverage that you have selected.

Q9 *WHEN MUST I DECIDE IF I WILL PAY FOR MY COVERAGE THROUGH THE PLAN?*

A9 You are required by Federal law to decide prior to the beginning of the Plan Year, during the "election period" (see Q & A 10), whether you want to pay for your medical and/or dental premiums under the Plan. Each eligible employee will receive a salary reduction agreement thirty (30) days before the Plan Year begins. The salary reduction agreement is your election form. Once you enroll in the Plan, you will be deemed to have elect to participate each Plan Year unless you indicate otherwise (see Q & A 12).

Q10 *WHEN IS THE ELECTION PERIOD FOR THE PLAN?*

A10 The election period begins on the date you first meet the eligibility requirements (see Q & A 2) and ends thirty (30) days after the date you are first eligible to join the Plan (see Q & A 3). The election period for each succeeding Plan Year will begin on December 1 and end on December 31.

Q11 *MAY I CHANGE MY ELECTIONS DURING THE PLAN YEAR?*

A11 Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, you are permitted to change your election if there is a change in your status. Currently, Federal law considers the following events to be changes in status:

- (1) You have a change in your marital status due to marriage, divorce, annulment, legal separation or death of a spouse.
- (2) The number of your Dependents (as defined in Section 152 of the Internal Revenue Code) changes, as a result of birth, death, adoption or placement for adoption.
- (3) You, your spouse or your Dependent has a change in employment status that affects that person's rights under this Plan or a benefit offered through this Plan.
- (4) You, your spouse or your dependent has a change in residence.
- (5) Your dependent experiences an event that causes him or her to satisfy or cease to satisfy the requirements for insurance coverage due to attainment of age, student status or similar circumstance.

You may also revoke your benefit election if the change corresponds with the special enrollment rights under Section 9801(f) of the Internal Revenue Code pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), results from a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires health coverage for your child, or if you, your spouse or your dependent becomes enrolled under Medicare or Medicaid (other than coverage only for pediatric vaccines).

The Internal Revenue Service has the authority to specify other events to be considered a change in status. The Town will notify you if and when the IRS changes the conditions qualifying as a change in status.

It is important to be aware that any change in your election must be on account of, and consistent with, the reason that such change was permitted. If you have a change in status, you must contact the Plan Administrator *within 31 days* of the change in status event. The Plan Administrator will provide you with the required forms for changing your benefit election.

In addition, with respect to medical and/or dental insurance premiums being contributed to the Plan, the Plan Administrator will adjust the salary reduction election you have made for the remainder of the Plan Year if there is a change in the premium expense. If the increase in premium expense is significant, you will be permitted to either change your salary reduction election or revoke your election entirely and elect to receive, on a prospective basis, coverage under another medical and/or dental plan with similar coverage. In addition, you may increase your contributions to the medical plan or the dental plan if you, your spouse or dependent child becomes eligible for continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or any similar state law.

Q12 *MAY I MAKE NEW ELECTIONS IN FUTURE PLAN YEARS?*

A12 For each new Plan Year, you may change the elections that you previously made. You may also choose not to participate in the Plan for the next Plan Year. If you do not make a new election during the "election period" (see Q & A 10) prior to the beginning of a Plan Year, you will be deemed to have elected the benefit options you had for the previous Plan Year.

E. PLAN BENEFITS

Q13 *WHAT INSURANCE COVERAGE MAY I ELECT TO PAY FOR ON A PRE-TAX BASIS?*

A13 Under the Plan, you can elect to receive your entire salary in cash or use a portion of your salary to pay premiums with pre-tax dollars for coverage under the Town's group:

- medical insurance plan
- dental insurance plan

Certain limits may apply on the amount of coverage that we obtain on your behalf. The insurance contracts will typically control in that case.

The Plan Administrator may terminate or modify Plan benefits at any time, subject to the provisions of the insurance contracts. The Town will not be liable to you if an insurance company fails to provide any of the benefits described above. Also, your insurance will end when you leave employment, are no longer eligible under the terms of any insurance policies, or when insurance coverage terminates.

Any benefits covered by insurance will be provided only after you have given the Plan Administrator the necessary information to apply for insurance and the insurance is in effect for you.

F. BENEFIT PAYMENTS

Q14 *WHEN WILL I RECEIVE BENEFIT PAYMENTS?*

A14 The amount of salary that you contribute to the Plan will be used to pay your share of the premiums for the insurance coverage that you have elected. The provisions of the insurance policies will control as to what benefits will be paid and when.

Q15 *WHAT HAPPENS IF THERE ARE EXCESS PLAN CONTRIBUTIONS?*

A15 You will not have to be concerned about estimating the amount contributed by you under the Plan from your salary to pay for your share of medical and/or dental premiums. Under the terms of the Plan, you elect to have the Town reduce your salary by the amount of salary necessary to pay for the coverage elected (your share of the group premium costs).

Q16 *WHAT HAPPENS IF I TERMINATE EMPLOYMENT?*

A16 If you terminate employment with the Town during the Plan Year, you will remain covered by insurance, but only for the period for which premiums have been paid prior to your termination of employment.

Under Federal law, you, your spouse, and your dependents may be entitled to continuation of health care coverage under the provisions of COBRA. The Plan Administrator will inform you of these rights if you terminate employment. If you have any questions concerning COBRA continuation coverage, contact the Plan Administrator.

It is your responsibility to notify the Plan Administrator of a change in your marital status, a change in your spouse's address, or a child losing dependent status under the Plan, within sixty (60) days of the event. It is the Town's responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, or Medicare eligibility.

Q17 *WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED?*

A17 Your Social Security benefits may be reduced (minimally) due to the fact that you receive pre-tax benefits under our Plan. The amount of contributions that you make to the Social Security system will be reduced, as well as the Town's contribution to Social Security on your behalf.

However, it is important to note that the tax advantages realized today with regard to participating in the Plan generally outweigh the relatively small impact such participation will have on your Social Security benefits.

If you have questions concerning the tax advantages of participating in the Plan, please consult with your tax advisor.

Q18 *WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE FROM THE TOWN?*

A18 If you take a paid leave of absence from the Town, your contributions under the Plan will continue on a pre-tax basis as if you were actively employed. However, if you take an unpaid leave of absence from the Town, including an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), you will have the opportunity to continue to pay for coverage under the insurance plans you have selected prior to the leave on a pre-tax basis or after-tax basis. You should consult with the Town before you take any leave of absence to review your options regarding this Plan.

G. HIGHLY COMPENSATED EMPLOYEES AND KEY EMPLOYEES

Q19 *DO LIMITATIONS APPLY TO HIGHLY COMPENSATED EMPLOYEES AND KEY EMPLOYEES?*

A19 Under the Internal Revenue Code of 1986, "highly compensated employees" and "key employees" generally are members who are shareholders, owners or highly paid employees.

If you are a highly compensated employee or a key employee, your contributions and benefits may be limited to prevent prohibited discrimination. A plan will be considered to unfairly favor the key employees if the key employees as a group receive more than 25% of all of the nontaxable benefits provided under the plan.

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

H. YOUR ERISA RIGHTS AND OTHER IMPORTANT INFORMATION

Q20 *WHAT ARE MY RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)?*

A20 As a member of the Plan, you may be entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan members shall be entitled to:

- (1) Examine, without charge, at the Plan Administrator's office, all Plan documents and related papers and copies of all documents filed on behalf of the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and
- (2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may impose a reasonable charge for the copies.

In addition to creating rights for Plan members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries", have a duty to do so prudently and in the interest of you and other Plan members and beneficiaries. No one, including the Town, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area office of the Pension and Welfare Benefits Administration of the U.S. Department of Labor or the Division of Technical Assistance and Inquiries, Pension Welfare Benefits Administration of the U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington DC 20210.

Q21 *HOW DO I MAKE A CLAIM FOR BENEFITS?*

A21 Claims for benefits that are insured will be reviewed in accordance with procedures contained in the insurance policies. All other general claims or requests should be directed to the Plan Administrator of the Plan. If a non-insured claim under the Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. If we fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the application to the Plan Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Plan Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding.