

# WELFARE EMPLOYEE BENEFIT PLAN DOCUMENTS

for

**CITY OF ABILENE**

Documents prepared by:



301 North Main Street, Suite 2000  
Wichita, Kansas 67202-4820

**Tel** (316) 267-2000 / **Fax** (316) 264-1518  
**Web** [www.hinklaw.com](http://www.hinklaw.com)

# CONTENTS

## CITY OF ABILENE

### WELFARE BENEFIT PLANS

### PLAN DOCUMENTS AND SUMMARY PLAN DESCRIPTIONS

<u>Summary of Plan Information</u>	<u>A</u>
<u>Cafeteria Plan</u>	<u>B</u>
<u>Cafeteria Plan Summary Plan Description</u>	<u>C</u>
<u>Employee Group Medical Plan</u>	<u>D</u>
<u>Employee Group Vision Plan</u>	<u>E</u>
<u>Prescription Drug Plan</u>	<u>F</u>
<u>Health Care Flexible Spending Account Plan</u>	<u>G</u>
<u>Dependent Care Spending Account Plan</u>	<u>H</u>
<u>AFLAC Pre-Tax Plan</u>	<u>I</u>
<u>AFLAC Pre-Tax Plan</u>	<u>J</u>
<u>AFLAC Pre-Tax Plan Summary Plan Description</u>	<u>K</u>
<u>Health Reimbursement Arrangement Plan</u>	<u>L</u>
<u>Health Reimbursement Arrangement Plan SPD</u>	<u>M</u>
<u>Health Reimb. Arrangement Plan Enrollment Form</u>	<u>N</u>
<u>Health Reimb. Arrangement Plan Reimbursement Claims Form</u>	<u>O</u>
<u>Minutes and Resolutions</u>	<u>P</u>
<u>Benefit Election / Salary Reduction Agreement</u>	<u>Q</u>
<u>Request to Change Pre-Tax Elections Form</u>	<u>R</u>
<u>Initial COBRA Notice</u>	<u>S</u>
<u>Checklists</u>	<u>T</u>

Hinkle Law Firm LLC  
Attorneys at Law

301 North Main Street, Suite 2000  
Wichita, Kansas 67202-4820  
(316) 267-2000  
Telefacsimile: (316) 264-1518

# **PLAN SUMMARY SHEETS**

**CITY OF ABILENE - WELFARE BENEFIT PLANS**

<b>Plan Name</b>	<b>Plan Number</b>	<b>Plan Funding</b>	<b>Insurance Company</b>	<b>Contract Number</b>	<b>Policy Anniversary</b>	<b>Plan Year</b>	<b>Plan Effective Date</b>	<b>Premiums are Paid:</b>
<b>Cafeteria Plan</b>	501	N/A	N/A	N/A	N/A	March 1 - February 28	March 1, 1997 (to be restated as of March 1, 2001)	N/A
<b>Medical (including Dental and Vision Coverage) (grandfathered)</b>	502	Fully-Insured	Preferred Health Systems	781101	March 1	March 1 - February 28	March 1, 2001	Pre-Tax through Cafeteria Plan
<b>Cancer Insurance</b>	503	Fully-Insured	AFLAC - Individual Contract	N/A	N/A	March 1 - February 28	March 1, 2001	Pre-Tax through Cafeteria Plan
<b>Short Term Disability Insurance</b>	504	Fully-Insured	AFLAC - Individual Contract	N/A	N/A	March 1 - February 28	March 1, 2001	After-Tax
<b>Personal Accident Plan</b>	505	Fully-Insured	AFLAC - Individual Contract	N/A	N/A	March 1 - February 28	March 1, 2003	Pre-Tax through Cafeteria Plan
<b>Personal Recovery Plus</b>	506	Fully-Insured	AFLAC - Individual Contract	N/A	N/A	March 1 - February 28	March 1, 2003	Pre-Tax through Cafeteria Plan
<b>Personal Intensive Care</b>	507	Fully-Insured	AFLAC - Individual Contract	N/A	N/A	March 1 - February 28	March 1, 2003	Pre-Tax through Cafeteria Plan
<b>Health Flexible Spending Account</b>	508	Self-Funded	Claims Administrator: AFLAC	N/A	N/A	March 1 - February 28	April 1, 2004	Pre-Tax through the Cafeteria Plan
<b>Dependent Care Assistance Plan</b>	509	Self-Funded	Claims Administrator: AFLAC	N/A	N/A	March 1 - February 28	April 1, 2004	Pre-Tax through the Cafeteria Plan
<b>Vision Plan</b>	510	Fully-Insured	VSP or Vision Care Direct	30013104 3568	March 1	March 1 - February 28	March 1, 2009	Pre-Tax through the Cafeteria Plan
<b>Prescription Drug Plan</b>	511	Self-Funded	Administered by: Serve You	3496	March 1	March 1 - February 28	March 1, 2010	Pre-Tax through the Cafeteria Plan
<b>Health Reimbursement Arrangement Plan</b>	512	Self-Funded	Administered by: Freedom Claims Management	N/A	March 1	March 1 - February 28	March 1, 2012	Pre-Tax through the Cafeteria Plan

**CITY OF ABILENE – SUMMARY OF ELIGIBILITY CONDITIONS  
CAFETERIA PLAN AND EMPLOYEE WELFARE BENEFIT PLANS**

<b>Plan</b>	<b>Plan Number</b>	<b>Hours per Week Requirement - Regularly Scheduled to Work:</b>	<b>Entry Date*</b>	<b>Example</b>
<b>Cafeteria Plan</b>	501	At least 20 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Medical (including Dental and Vision Coverage) (grandfathered)</b>	502	At least 20 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Cancer Insurance Plan</b>	503	At least 30 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Short Term Disability Insurance Plan</b>	504	At least 30 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Personal Accident Plan</b>	606	At least 30 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Personal Recovery Plus</b>	506	At least 30 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Personal Intensive Care</b>	507	At least 30 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Health Flexible Spending Account</b>	508	At least 20 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Dependent Care Assistance Plan</b>	509	At least 20 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Vision Plan</b>	510	At least 30 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Prescription Drug Plan</b>	511	At least 20 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.
<b>Health Reimbursement Arrangement Plan</b>	512	At least 20 hours per week	First day of month following one day of employment	(1) Employee hired March 31 will enter plan on April 1; (2) Employee hired on April 1 will enter plan on April 1.

\* If they are hired on the first working day of the month, they are eligible that same day.

**CITY OF ABILENE**

**CAFETERIA PLAN**

**CITY OF ABILENE  
CAFETERIA PLAN**

The City of Abilene, Kansas, (“Employer”) adopts this amended and restated Cafeteria Plan for the benefit of its Eligible Employees. This Cafeteria Plan is an amendment and restatement of the Plan originally adopted effective March 1, 1997, as subsequently amended and restated March 1, 2001, and March 1, 2003.

**ARTICLE I  
PURPOSE AND LEGAL STATUS OF THE PLAN**

Section 1.01 Purpose of Plan. The purpose of this Plan is to provide Eligible Employees of the Employer a choice between taxable compensation and nontaxable benefits from Component Benefit Plans maintained by the Employer.

Section 1.02 Cafeteria Plan Status. It is the intent of the Employer that this Plan qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code, as amended, and the regulations issued thereunder, and that any “qualified benefits” paid under this Plan be eligible for exclusion from the Participant’s gross income for federal income tax purposes.

Section 1.03 Exclusive Benefit. It is intended that the Plan terms, including those related to coverage and benefits, be legally enforceable and that this Plan be maintained for the exclusive benefit of Employees.

*[The remainder of this page intentionally left blank.]*

## **ARTICLE II DEFINITIONS**

Section 2.01 “Annual Enrollment Period” means the period defined in Section 4.03(b) of this Plan.

Section 2.02 “Cafeteria Plan” or “Plan” means the City of Abilene Cafeteria Plan.

Section 2.03 "Claim" means any request for a Plan benefit or benefits made by a Claimant in accordance with the Plan’s procedures for filing benefit claims as set forth in the Medical Plan and/or Prescription Drug Plan Component Benefit Plan.

Section 2.04 "Claimant" means a Participant who files a Claim for benefits pursuant to the plan’s procedures for filing benefit claims as set forth in the Medical Plan and/or Prescription Drug Plan.

Section 2.05 “Claims Administrator” means the Plan Administrator, unless the Employer retains a company or companies to function, on an insured or contract administration basis, in making determinations to grant or deny claims for benefits under a Component Benefit Plan.

Section 2.06 “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.07 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.08 “Compensation” means wages, salary and other remuneration paid to a Participant by the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan on behalf of the Participant, and does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.09 “Component Benefit Plan” means any of the following plans:

- (a) City of Abilene Employee Group Medical Plan;
- (b) City of Abilene AFLAC Pre-Tax Plan;
- (c) City of Abilene Health Flexible Spending Account Plan;
- (d) City of Abilene Dependent Care Assistance Plan;
- (e) City of Abilene Employee Group Vision Plan; and/or
- (f) City of Abilene Prescription Drug Plan.

Section 2.10 “Election Change Event” means an event which would allow a Participant to change the Participant’s elections during a Plan Year, subject to the requirements of Article IV and as set forth in more detail in Sections 4.06 through 4.15.

Section 2.11 “Effective Date” means the original date on which this Plan took effect, which date is March 1, 1997; provided, however, that if this Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.12 “Eligible Employee” means an Employee, other than a Temporary Employee, actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding twenty (20) hours per week, subject, however, to the following:

- (a) *Status During Leaves of Absence.* An Employee’s status as an Eligible Employee shall be deemed to continue during any paid leave of absence approved by the Employer, during an unpaid leave of absence if approved by the Employer, or, if the FMLA is applicable to the Employer, during a leave of absence taken pursuant to the FMLA.
- (b) *Status During Military Service.* An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less.
- (c) *Thirty (30) Hour Requirement for Some Plans.* Notwithstanding the above, in order to be eligible to participate in the following Plans, an Employee must be regularly scheduled to work at least thirty (30) hours per week:
  - (1) City of Abilene AFLAC Pre-Tax Plan; and/or
  - (2) City of Abilene Employee Group Vision Plan.

Section 2.13 “Employee” means an individual employed by the Employer, excluding those persons covered by a collective bargaining agreement and further excluding those persons classified by the Employer on its payroll records as "leased employees" as that term is used in Section 414(n) of the Code.

Section 2.14 “Employer” means the City of Abilene, Kansas.

Section 2.15 “FMLA” means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.16 “Group Health Plan” means, for purposes of the HIPAA, COBRA, and FMLA provisions in Articles III and IV, a Component Benefit Plan that provides health care to the participants in the plan and their beneficiaries. The term includes the following Component Benefit Plans:

- (a) City of Abilene Employee Group Medical Plan;
- (b) City of Abilene Health Flexible Spending Account Plan;
- (c) City of Abilene Employee Group Vision Plan; and
- (d) City of Abilene Prescription Drug Plan.

Section 2.17 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

Section 2.18 “Participant” means an Eligible Employee who has entered the Plan pursuant to Section 3.01 and whose participation in the Plan has not been terminated pursuant to Section 3.02.

Section 2.19 “Plan Administrator” means the Employer unless the Employer specifically appoints another person or committee to supervise the administration of this Plan.

Section 2.20 “Plan Year” means the fiscal year of this Plan, the twelve (12) consecutive month period ending every February 28.

Section 2.21 “Temporary Employee” means an Employee scheduled to fill job requirements which occur intermittently or are created as a result of a federal or state grant of limited duration for a program or project.

Section 2.22 “USERRA” means the Uniformed Services Employment and Reemployment Act of 1994, as amended from time to time.

Section 2.23 “Utilization Review” means a claims review process in which medical personnel are consulted regarding medical necessity. This includes reviewing the need for inpatient admissions, the appropriateness of the patient’s length of stay, and the appropriate use of tests and procedures in relation to the diagnosis and treatment of the patient’s condition. The review is made solely for purposes of the payment of benefits in accordance with this Plan. The Utilization Review organization is designated by the Plan Administrator or, if so provided by contract, the Claims Administrator.

*[The remainder of this page intentionally left blank.]*

**ARTICLE III  
PARTICIPATION IN THE PLAN**

Section 3.01 Entry into the Plan.

- (a) *General Rule.* An Eligible Employee becomes a Participant on the first day of the month following or coincident with one day of active employment. An Eligible Employee who has entered into the Plan under this Section 3.01 is a Participant without regard to whether he or she elects to reduce his/her Compensation in order to purchase benefits under one or more of the Component Benefit Plans.
- (b) *Effective Date of this Plan.* Notwithstanding any other provision of this Plan, no Eligible Employee may become a Participant prior to the Effective Date of this Plan.
- (c) *Former Participants.* If a former Participant terminates employment, is later rehired, and becomes an Eligible Employee after being rehired, the former Participant will again become a Participant in the Plan pursuant to the provisions of Section 3.01(a). The elections of a former Participant who reenters the Plan within thirty (30) days after the date on which he or she ceased to be a Participant are subject to the provisions of Section 4.19.

Section 3.02 Termination of Participation.

- (a) *General Rule.* A Participant will cease participation in this Plan on the earlier of the following dates:
  - (1) The date on which this Plan terminates; or
  - (2) The date on which the Participant ceases to be an Eligible Employee, regardless of whether the Participant ceases to be an Eligible Employee due to the termination of his/her employment or as a result of changing from full-time to part-time employment.

Although a Participant's participation under this Plan terminates on the above date, coverage or benefits under the Component Benefit Plans may continue if and to the extent provided by such Component Benefit Plans.

- (b) *Special Rule for COBRA Continuation Coverage.* Notwithstanding the general rule stated in Section 3.02(a), a Participant who is no longer an Eligible Employee may continue to participate in this Plan for the limited purpose of paying through this Plan the cost of any COBRA continuation coverage to which the Participant might be entitled.

Section 3.03 Family and Medical Leave Act of 1993.

- (a) *General Rule.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain the Participant's benefits under a Group Health Plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). If the Participant is a participant in the Health FSA, additional rules may apply to the Participant's coverage under the Health FSA as stated in the plan document for the Health FSA.

- (b) *Options for Payment of Participant's Share of the Premium.* If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one or more of the following ways:
- (1) The Participant may pay his/her share of the premiums with after-tax dollars while on leave (or with pre-tax dollars to the extent the Employee receives Compensation during the leave).
  - (2) The Participant may be given the option to pre-pay all or a portion of his/her share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his/her pre-leave Compensation by making a special election to that effect prior to the date such Compensation would normally be made available to the Participant. The Participant may not, however, use pre-tax dollars during the current Plan Year to fund coverage that will be provided during a subsequent Plan Year.
  - (3) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.
- (c) *Return from FMLA Leave.* If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that the Participant was participating in the Plan prior to his/her leave, or as otherwise required by the FMLA.

*[The remainder of this page intentionally left blank.]*

**ARTICLE IV  
ELECTION OF BENEFITS**

Section 4.01 Benefit Choices. Each Participant may elect to receive the Participant's entire Compensation in cash or to reduce the Participant's Compensation and have the Employer apply the amount by which the Participant's Compensation is reduced toward the cost of benefits available under one or more of the Component Benefit Plans. The exact terms and conditions of each Component Benefit Plan are set forth in such Component Benefit Plan.

Section 4.02 Method of Making an Election. In order to purchase through this Plan the benefits that are available under one or more of the Component Benefit Plans, a Participant must execute an agreement to reduce Compensation on the salary reduction form provided by the Plan Administrator.

Section 4.03 Timing of Elections.

- (a) *Initial Elections for New Participants.* To make an election to purchase benefits through this Plan, a new Participant must execute a salary reduction form and deliver it to the Plan Administrator no later than thirty (30) days after the date the Participant becomes a Participant in this Plan. The Participant's election will be given effect as of the earliest administratively practicable date following the date on which the Participant delivers the salary reduction form to the Plan Administrator, provided that no such election may take effect prior to the date the Participant becomes a Participant in this Plan.
- (b) *Annual Elections for Current Participants.* At least thirty (30) days prior to the beginning of each Plan Year, the Plan Administrator must provide each Participant with the opportunity to make elections for the following Plan Year. Participants desiring to make elections during the Annual Enrollment Period for the next Plan Year must do so in the manner and within the deadlines prescribed by the Plan Administrator. Elections made during the Annual Enrollment Period shall become effective for the following Plan Year.
- (c) *Election Changes during a Plan Year.* A Participant may change his/her elections during a Plan Year *only if* an election change is permitted as a result of one or more of the events listed in Sections 4.06 through 4.15. Such events may be referred to generally in Plan documents as a "Election Change Event." Any election change as a result of an event qualifying as a Election Change Event must be made no later than thirty (30) days after the event. Election changes made as a result of an Election Change Event may *not* be given retroactive effect except as specifically set forth below. Additional restrictions and/or rules may apply to election changes made during a Plan Year with respect to a Health FSA and/or a DCAP.

Section 4.04 Failure to Make an Election.

- (a) *Failure to Make Initial Election.* A Participant's failure to return a completed salary reduction form by the required date as set forth in Section 4.03(a) constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash. In such an event, no portion of the Employee's Compensation will be applied toward the cost of any benefits available under any of the Component Benefit Plans. Such an Employee will not be permitted to change such an election until (1) the next Annual Enrollment Period *or* (2) the Employee experiences a Election Change Event, as a result of which an election change would be permitted under this Article IV.

- (b) *Failure to Change Existing Elections During Annual Enrollment Period.* Once a Participant has completed a salary reduction form for a Plan Year, a failure to complete a new form for a subsequent Plan Year during the Annual Enrollment Period constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash.

Section 4.05 Irrevocability of an Election Once Made. Once the Annual Enrollment Period has passed, a Participant shall not be permitted to revoke, amend, or change the elections the Participant has made for the affected Plan Year except as provided in Sections 4.06 through 4.15 of this Plan.

Section 4.06 Election Change Due to Change in Status. After a Plan Year has commenced, a Participant shall be permitted to revoke an election in its entirety (or revoke the election and make a new election) for the balance of that Plan Year, if the Participant experiences a Change in Status as defined below and the requirements of this Section 4.06 are satisfied.

- (a) *Change in Status.* The following events constitute a Change in Status:

- (1) *Change in Marital Status.* A change in the Participant's legal marital status, including the following: Marriage, divorce, the death of a spouse, legal separation, and annulment.
- (2) *Change in Number of Dependents.* A change in the number of the Participant's dependents, including the following: Birth, death, adoption, and placement for adoption.
- (3) *Change in Employment Status.* Any of the following events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent(s):
  - (i) A termination or commencement of employment;
  - (ii) A commencement of or return from an unpaid leave of absence;
  - (iii) A change in worksite, if such a change affects eligibility under this Plan or a Component Benefit Plan;
  - (iv) A change in employment status, such as a change from salaried to hourly employment, if the change affects the eligibility of the Participant, the Participant's spouse, or the Participant's dependent(s) under this Plan or under a Component Benefit Plan or if the change affects the eligibility of the Participant, the Participant's spouse, or the Participant's dependent(s) under a cafeteria plan or welfare benefit plan maintained by an employer (other than the Employer) employing the Participant, the Participant's spouse, or the Participant's dependent(s);
- (4) *Change in Dependent Eligibility.* An event that causes the Participant's dependent(s) to satisfy or cease to satisfy the eligibility conditions for coverage under a Component Benefit Plan on account of the dependent's attainment of a certain age, student status, or any similar circumstances.
- (5) *Change in Residence.* A change in the place of residence of the Participant, the Participant's spouse, or the Participant's dependent(s), if such a change affects eligibility under this Plan or a Component Benefit Plan.

- (6) *Adoption Proceedings.* For purposes of adoption assistance provided through this Plan only, the commencement or termination of an adoption proceeding.
- (b) *Consistency.* An election change that is made on account of a Change in Status must be consistent with that Change in Status. Whether a particular election change is consistent with a Change in Status will be determined by the Plan Administrator in accordance with Internal Revenue Service regulations.

Section 4.07 Election Change Due to Exercise of HIPAA Special Enrollment Rights.

- (a) *HIPAA Special Enrollment Rights.* After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage, if the Participant, the Participant's spouse, or a dependent of the Participant is entitled to special enrollment rights under a group health plan of the Employer as described under either (1), (2), (3) or (4) below:
  - (1) Eligibility for a State Premium Assistance Subsidy under the Plan from Medicaid or SCHIP. A Participant or his/her spouse or dependent becomes eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP);
  - (2) Loss of Eligibility for Medicaid or SCHIP Coverage. The Medicaid or SCHIP coverage of a Participant or his/her spouse or dependent is terminated as a result of a loss of eligibility.
  - (3) Loss of Other Coverage. Medical coverage was declined under a group health plan sponsored by the Employer because the Employee and/or dependent was covered under another group health plan or had other health insurance coverage, and eligibility for such coverage is subsequently lost. A loss of eligibility for such other coverage includes the following:
    - (i) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period;
    - (ii) Loss of eligibility due to the incurrence of a claim causing the individual to meet or exceed a lifetime limit on all benefits;
    - (iii) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area (whether or not the choice of the individual); and
    - (iv) In the case of coverage offered through an HMO in the group market that does not provide benefits to an individual who no longer resides, lives or works in the service area (whether or not the choice of the individual), and no other benefit package is available to the individual.

A loss of eligibility does not include a loss resulting from the failure of the Employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud).

- (4) Acquisition of a New Dependent. The Participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption.
- (b) *New Election Must Correspond and be Consistent with HIPAA Special Enrollment Rights.* A change in elections pursuant to this Section 4.07 must correspond and be consistent with the exercise of the special enrollment rights provided under Code § 9801(f).
    - (1) *Increase in Salary Reductions.* A Participant may elect to increase the amount by which his or her Compensation is reduced by no more than the additional cost of the benefits provided under the group health plan as a result of the enrollment of the Participant, the Participant's spouse, and/or a dependent of the Participant in the group health plan.
    - (2) *Decrease in Salary Reductions.* A Participant may elect to decrease the amount by which his/her Compensation is reduced by no more than the cost of the premium assistance received by the Participant and/or his/her dependents.
    - (3) *Election to Add Previously Eligible Dependents.* An election to add previously eligible dependents as a result of a loss of other coverage or the acquisition of a new spouse or dependent child shall be considered to be consistent with the special enrollment rights.
  - (c) *Status Change Form.* Each Participant must complete a status change form and submit such form to the Plan Administrator no later than 60 days after the date of the event giving rise to the exercise of a HIPAA special enrollment right under (a)(1) or (a)(2) above, or no later than 30 days after the date of the event giving rise to the right to exercise the special enrollment rights under (a)(3) or (a)(4) above.
  - (d) *Effective Date of Medicaid/SCHIP Provisions.* The effective date of the HIPAA special enrollment right provisions set forth in Subsections (a)(1) and (a)(2) is April 1, 2009.
  - (e) *Approval of Change.* Any change in election resulting from the exercise of the special enrollment rights provided under Code § 9801(f) is subject to the review and approval of the Plan Administrator.

Section 4.08 Election Change due to Change in Coverage.

- (a) *Cessation or Significant Curtailment in Coverage.* If the Plan Administrator determines that coverage under a Group Health Plan ceases or is significantly curtailed during the Plan Year, the Participant may revoke his/her election for coverage under that Group Health Plan and may elect coverage, on a prospective basis only, under another Group Health Plan that provides similar coverage. Coverage under a Group Health Plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Group Health Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a curtailment is "significant" and whether a substitute Component Benefit Plan constitutes "similar coverage" based upon all of the surrounding facts and circumstances.

- (b) *Addition or Elimination of Benefit Package Option.* If, during the Plan Year, a Component Benefit Plan is added, a Participant who is affected by the change may elect to add the new Component Benefit Plan and to make corresponding changes with respect to other Component Benefit Plans providing similar coverage. Any such change will take effect on a prospective basis only. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a substitute Component Benefit Plan constitutes “similar coverage” based upon all of the surrounding facts and circumstances.
  
- (c) *Change in Coverage of Spouse or Dependent under Plan of Another Employer (“Election Lock”).* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only if the change is on account of and corresponds with a change made under the plan of the employer of the Participant’s spouse, the Participant’s former spouse, or the Participant’s dependent. Any such change is permitted only if (1) the cafeteria plan of such other employer permits its participants to make only those election changes that are permitted under proposed or final Internal Revenue Service regulations under Code Section 125; or (2) the period of coverage under the plan of such other employer is different than the Plan Year for this Plan. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a requested change is on account of and corresponds with a change made under the plan of the employer of the Participant’s spouse, former spouse, or dependent. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination.

Section 4.09 Election Change due to FMLA Leave. A Participant who is taking leave under the FMLA may revoke an existing election of Group Health Plan coverage and may make such other election for the remaining portion of coverage as may be permitted under Section 3.03 of this Plan. Additionally, such a Participant may also be permitted to change his/her elections under Section 4.03(c), provided the requirements of that section are satisfied.

Section 4.10 Election Change due to Exercise of COBRA Rights. A Participant may increase the amount of his/her election to pay for the cost of COBRA coverage under a Group Health Plan if a COBRA event (or an event under a similar state law providing for continuation coverage) occurs with respect to the Participant, the Participant’s spouse, or a dependent of the Participant. This Section 4.10 does not apply to COBRA coverage under a plan sponsored by some other employer.

Section 4.11 Election Change due to Issuance of a Judgment, Decree or Order. If a judgment, decree, or order (an “Order”) resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage to be provided for a Participant’s dependent child, including a foster child who is a dependent of the Participant, a Participant may (a) change his/her election to provide coverage for the dependent child, provided that the Order requires the Participant to provide such coverage; or (b) change his/her election to revoke coverage for the dependent child if the Order requires that another individual, including the Participant’s spouse or former spouse, provide coverage under that individual’s plan.

Section 4.12 Election Change due to Medicare / Medicaid Entitlement. If a Participant, a Participant’s spouse, or a Participant’s dependent who is entitled to receive benefits under a Group Health Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits of Section 1928 of the Social Security Act providing for pediatric vaccines), and the Participant may reduce his/her election to reflect the reduction or cancellation of the coverage provided to such person under the Group Health Plan. Additionally, if a Participant, a Participant’s spouse, or a Participant’s dependent who has been

entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may increase his/her election to reflect the increased cost of providing coverage under the Group Health Plan. Any change made under this Section 4.12 shall take effect on a prospective basis only. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination. The right to drop or add coverage under a Group Health Plan is governed by and subject to the terms of the Group Health Plan. This Section 4.12 does not apply to a Health FSA.

Section 4.13 Election Change due to Significant Change in Cost.

- (a) *Increase in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) increases by a significant amount during a Plan Year, the Participant may either increase his/her election by a corresponding amount on a prospective basis or the Participant may revoke his/her election and, in lieu thereof, receive coverage under another Benefit Package Option (if any) providing similar coverage. If similar coverage is not available under another Benefit Package Option, the Participant may revoke his/her election without electing coverage under another Benefit Package Option.
- (b) *Decrease in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) decreases by a significant amount during a Plan Year, the Participant may decrease his/her election by a corresponding amount on a prospective basis or, if the Participant is not currently enrolled in the Benefit Package Option, the Participant may elect to become covered under that Benefit Package Option.
- (c) *Other Provisions.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing Internal Revenue Service guidance, whether a change in cost is significant and what constitutes "similar coverage" based upon all of the surrounding facts and circumstances.
- (d) *Special Provisions Applicable to DCAP's.* This Section 4.13 does not apply to a DCAP unless the change in cost is imposed by a dependent care provider who is not related (as that term is used in Internal Revenue Service Regulations) to the Participant.

Section 4.14 Election Change Required by the Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount by which they have elected to reduce their Compensation for a Plan Year if the Plan Administrator determines such action is necessary or advisable to (a) satisfy any Code nondiscrimination requirements applicable to this Plan or any Component Benefit Plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits from any Component Benefit Plan than would otherwise be recognized; or (c) maintain the qualified status of benefits received under this Plan. In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the amount by which each affected Participant has elected to reduce his/her Compensation, beginning with the Participant in the class who had elected to reduce his/her Compensation by the highest amount, continuing with the Participant in the class who had elected the next highest amount, and so forth, until the defect is corrected.

Section 4.15 Automatic Election Change for Insignificant Changes in Cost. If the Participant's share of the premium or cost for the benefits provided under a Component Benefit Plan increases or decreases during the Plan Year by an insignificant amount, the Participant's election shall be increased or decreased on a prospective basis by the amount of such increase or decrease. The Plan Administrator, on a reasonable

and consistent basis, shall automatically effectuate this prospective increase or decrease in the elective contributions of the affected Participants in accordance with such cost changes. The Plan Administrator, in its sole discretion, shall decide whether increases or decreases in cost are “insignificant” based upon all of the surrounding facts and circumstances, including, but not limited to, the dollar amount and/or the percentage amount of the change.

Section 4.16 Requesting and Approving Election Changes. A Participant desiring to make a change in his/her elections pursuant to this Article IV must complete and submit a status change form and/or such other forms as the Plan Administrator may require. If an election change is to take effect during a Plan Year, the Plan Administrator may require the Participant to provide such proof as it reasonably considers necessary of the events underlying the request for an election change, including, but not limited to, a marriage certificate, divorce decree, birth certificate, confirming letter from the spouse’s current or former employer, or any other relevant documents. All such requests for an election change must be reviewed and approved by the Plan Administrator before the election change is given effect. All such requests must be submitted within thirty (30) days after the date giving rise to the request for an election change, except as provided in Section 4.07(c) with regard to certain HIPAA special enrollment rights that allow such requests to be submitted within 60 days after the date giving rise to the request for an election change.

Section 4.17 Effective Date of Election Changes. Except as specifically provided in this Section 4.17, an election change made during the middle of a Plan Year will be given prospective effect only and will take effect as of the first administratively practicable date following the date on which the Plan Administrator approves the new elections that are being made.

- (a) *Special Rule for Newly Adopted Dependent Children and Newborns.* Notwithstanding the general rule stated in this Section 4.17, and subject to the provisions of the underlying Group Health Plan, an election to increase the amount by which the Participant’s Compensation is reduced in order to fund the increased cost of providing benefits under a Group Health Plan to a newly adopted dependent child or newborn may be given retroactive effect to the date of birth or date of adoption.

Section 4.18 Special Rule for Health FSA’s. Notwithstanding any provision of this Article IV to the contrary, a Participant may not change the amount of his/her election with respect to the Health FSA during a Plan Year, except that, if an election change is permitted by this Article IV, a Participant (a) may cease to participate in the Health FSA by changing the amount of his/her election to zero; or (b) may begin to participate in the Health FSA for the balance of the Plan Year if the Participant had not previously participated in the Health FSA during the Plan Year.

Section 4.19 Elections of Former Participants Rehired Within Thirty Days of Termination. If a former Participant is rehired within thirty (30) days after the date on which the Participant’s employment relationship with the Employer was terminated, the Participant will be reinstated with the same elections the Participant had before termination unless (a) the Participant would be permitted to make an election change under Article IV for a reason other than a change in his/her employment with the Employer or (b) the Plan Year ended on or after the date on which the employment relationship was terminated but before the date of reinstatement.

Section 4.20 Maximum Benefits. The maximum benefits under this Cafeteria Plan are the maximum benefits specified in the Component Benefit Plans.

*[The remainder of this page intentionally left blank.]*

**ARTICLE V  
PLAN ADMINISTRATION**

Section 5.01 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. The Plan Administrator shall have the responsibility of ensuring that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the persons entitled to participate in this Plan.

Section 5.02 Powers of the Plan Administrator. The Plan Administrator shall have such powers and duties as it considers necessary or appropriate to discharge its duties under this Plan. The powers of the Plan Administrator shall include, but are not limited to, the following:

- (a) To establish rules and procedures for the purpose of administration of this Plan;
- (b) To require each Participant to supply such information and sign such documents as may be necessary to administer this Plan;
- (c) To interpret, construe and carry out the provisions of this Plan and render decisions on the administration of this Plan, including decisions on Employee eligibility and participation; and
- (d) To appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as may be needed for proper administration of this Plan.

The Plan Administrator shall have no power to alter the terms of this Plan or to waive or fail to apply any requirements governing eligibility or participation.

Section 5.03 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Plan in a nondiscriminatory manner so all persons similarly employed by the Employer will receive substantially the same treatment.

*[The remainder of this page intentionally left blank.]*

**ARTICLE VI  
TERMINATION AND AMENDMENT OF THE PLAN**

The Employer may amend or terminate this Plan at any time by written instrument signed by the City Manager of the Employer.

*[The remainder of this page intentionally left blank.]*

## **ARTICLE VII MISCELLANEOUS**

Section 7.01 Funding and Expenses. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. All administrative costs shall be borne by the Employer.

Section 7.02 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Plan except to the extent superseded by Federal law.

Section 7.03 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 7.04 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent that the benefits payable under the Component Benefit Plans are payable solely from the assets of the Employer.

Section 7.05 Nonalienation of Benefits. Benefits payable under the Component Benefit Plans are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, except pursuant to court order, prior to actual receipt by the person entitled to the benefit under the terms of this Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable under the Component Benefit Plans is void. The Employer is not in any manner liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under this Plan.

Section 7.06 Employment Not Guaranteed. Nothing contained in this Plan or in any other plan which is a part of the Plan, or any modification or amendment to this Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Plan.

Section 7.07 Named Fiduciary. The named fiduciary of this Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Plan.

Section 7.08 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 7.09 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 7.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Plan on a retroactive basis.

Section 7.11 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;
- (b) The amounts the Participant has elected to defer into a qualified plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this plan or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

*[The remainder of this page intentionally left blank.]*

IN WITNESS WHEREOF, the Employer adopts this amended and restated Plan effective the 1st day of March, 2001.

City of Abilene

By: \_\_\_\_\_  
Mark F. Arbuthnot, City Manager

**CITY OF ABILENE**

**CAFETERIA PLAN**

**Summary Plan Description**

**CITY OF ABILENE CAFETERIA PLAN  
SUMMARY PLAN DESCRIPTION  
TABLE OF CONTENTS**

1.	General Information .....	1
2.	Cafeteria Plan - Participation in the Plan.....	2
3.	Cafeteria Plan - Participant Elections .....	3
4.	Employee Group Medical Plan.....	7
5.	Prescription Drug Plan.....	8
6.	Health Flexible Spending Account Plan.....	10
7.	Dependent Care Assistance Plan .....	15
8.	Employee Group Vision Plan .....	19
9.	AFLAC Pre-Tax Plan .....	20
10.	COBRA Coverage for Group Health Plans .....	21
11.	USERRA Continuation Rights .....	30
12.	Recovery of Benefits by the Prescription Drug Plan.....	30
13.	Prescription Drug Plan Claims Procedures.....	31
14.	Miscellaneous .....	35
15.	Notice of Hospital Rights for Newborns and Mothers .....	35
16.	Notice of Rights under the Women’s Health and Cancer Rights Act of 1998 .....	36
17.	Notice of Opportunity to Enroll Adult Children to Age 26.....	36
18.	No Lifetime Limit under the Medical Plan.....	36
19.	Grandfathered Status Notice for the Medical Plan .....	37
20.	Right of Employer to Amend or Terminate.....	37
	COBRA Notice Procedures .....	A-1

**SUMMARY PLAN DESCRIPTION  
CITY OF ABILENE CAFETERIA PLAN**

The City of Abilene, Kansas, (“Employer”) maintains the City of Abilene Cafeteria Plan (the “Plan” and/or the “Cafeteria Plan”) for the exclusive benefit of, and to provide benefits to, its eligible employees, their legal spouses, and their eligible dependents.

This Summary Plan Description describes the basic features of the Plan, how the Plan operates, and the benefits that can be purchased through the Plan. This Summary Plan Description is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. *If there is a conflict between the plan documents and this Summary Plan Description, the plan documents will control.*

**(1) General Information**

- (a) *Type of Plan.* This Plan is a cafeteria plan. The Employer has assigned number 501 as the Plan Number for this Plan.
- (b) *Component Benefit Plans.* Participants in the Cafeteria Plan may reduce their salary on a pre-tax basis to pay for the cost of benefits provided by one or more of the following “Component Benefit Plans” maintained by the Employer:
  - (1) City of Abilene Employee Group Medical Plan (Plan Number 502);
  - (2) City of Abilene AFLAC Pre-Tax Plan (Plan Number 503);
  - (3) City of Abilene Health Care Savings Account Plan (Plan Number 508);
  - (4) City of Abilene Dependent Care Assistance Plan (Plan Number 509);
  - (5) City of Abilene Employee Group Vision Plan (Plan Number 510); and
  - (6) City of Abilene Prescription Drug Plan (Plan Number 511).

Each of these Component Benefit Plans is governed by a separate plan document. Please refer to such documents for information regarding specific terms and conditions associated with each Plan. This Summary Plan Description serves as the summary plan description for each of these Component Benefit Plans. A summary of each of these Plans is provided later in this Summary Plan Description.

- (c) *Taxation.* The amount by which your salary is reduced to purchase benefits under the Component Benefit Plans and any benefits paid to you under the Component Benefit Plans will not be included in your taxable income for Federal income tax purposes and are not subject to FICA taxes.
- (d) *Employer.* The name, address, telephone number, and Federal tax identification number of the Employer are:

**City of Abilene  
P.O. Box 519  
Abilene, Kansas 67410  
(785) 263-2550  
EIN: 48-6017973**

- (e) *Plan Administrator / Service of Process.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Internal Revenue Service. The name of the person designated as the Agent for Service of Legal Process is Penny Soukup, whose address is the same as the Employer's address.
- (f) *Plan Year.* The Plan Year means the fiscal year of the Plan, the twelve (12) consecutive month period ending every February 28.

## **(2) Cafeteria Plan – Participation in the Plan**

You will automatically become a Participant in the Cafeteria Plan on your plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

- (a) *Eligibility Conditions.* To be eligible to participate in the Plan, the following conditions must be met:
  - (1) *Employee.* You must be an individual employed by the Employer;
  - (2) *Regularly Scheduled Hours Per Week.* Your regularly scheduled workweek must ordinarily equal or exceed 20 hours per week;
  - (3) *One Day of Employment.* You must have completed one day of active employment with the Employer; and
  - (4) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (i) covered under a collective bargaining agreement; or (ii) classified on the Employer's payroll records as a "temporary" employee or a "leased" employee.
- (b) *Plan Entry Date.* If all of the eligibility conditions have been met, you will enter the Plan on the first day of the month following or coincident with your first day of active employment.

*EXAMPLE #1.* You begin working as a full-time employee on January 15. You will automatically enter the Plan on the first day of the next month, which is February 1.

*EXAMPLE #2.* You begin working as a full-time employee on January 1, which is the first working day of the month. You will automatically enter the Plan on the same day, which is January 1.

(c) *Termination of Participation.* Once you become a Participant, you will continue to be a Participant as long as each of the eligibility conditions is met. If one or more of these conditions is not met, you will cease to be a Participant, unless a special rule applies. The special rules that might apply are summarized below.

(1) *Special Rule for Leaves of Absence.* If the number of hours that you are regularly scheduled to work each week falls below the minimum number required for you to participate in this Plan, you may still continue to participate in this Plan if you are on (i) a paid leave approved by the Employer; (ii) unpaid leave under the Family and Medical Leave Act (“FMLA”) if the FMLA is applicable to the Employer; or (iii) unpaid leave of absence approved by the Employer.

(2) *Special Rule for Military Service.* If you enter active service in the armed forces of any country, you will not be eligible to participate in the Plan unless your service is temporary active service of two (2) weeks or less.

### **(3) Cafeteria Plan – Participant Elections**

To purchase benefits on a pre-tax basis through the Cafeteria Plan, you must elect (the “Election”) to do so by completing and returning a Salary Reduction Agreement to the Plan Administrator. Once you have made an Election, you will not be able to change that Election until the next Plan Year, unless an exception applies. These rules are discussed in more detail below.

(a) *How to make an Election.* To make an Election, you must complete a Salary Reduction Agreement and return the completed Agreement to the Plan Administrator. If you are changing an Election in the middle of a Plan Year, you may also be required to complete and return an Election Change form.

(b) *When to make an Election.* An Election for the next Plan Year must be made during the Annual Enrollment Period for that Plan Year. The Annual Enrollment Period will be announced by the Plan Administrator each year. An Election change during the middle of a Plan Year must be made no later than 30 days after the event that allows an Election change to be made, except that an Election change made in connection with certain HIPAA special enrollment rights may be made within sixty (60) days after the event as further described in (3)(d)(2) below. If you are a new Participant in the Plan, an Election must be made no later than 30 days after the date you entered the Plan.

(c) *Failure to make an Election.*

(1) *Failure to Make an Initial Election.* If you have never made an Election, you will not be able to purchase any benefits through the Plan on a pre-tax basis.

(2) *Failure to Change Existing Election.* Once you have made an Election, a failure to complete a new Salary Reduction Agreement for a subsequent Plan Year will be treated as a decision on your part to receive all of your Compensation in cash.

(d) *Election Changes.* An Election may not be changed in the middle of a Plan Year unless you qualify for one of the exceptions listed below. All Election changes must be approved by the Plan Administrator. In approving or denying an Election change, the Plan Administrator may rely on the terms of the Plan, Internal Revenue Service Regulations, and informal guidance from the Internal Revenue Service (the “IRS”).

You may change an Election in the middle of a Plan Year in the following circumstances (and subject to the other rules of the Plan):

- (1) *Change in Status.* If there is a “change in status” and the Election change is consistent with the “change in status.” The following events may constitute a “change in status”:
  - (i) A change in your marital status;
  - (ii) A change in the number of your dependents;
  - (iii) A change in the employment status of yourself, your spouse, or your dependent. This may include starting a new job, leaving an old job, taking an unpaid leave of absence, or returning from an unpaid leave of absence. It may also include a change in the number of hours that you, your spouse, or your dependent are regularly scheduled to work, but only if the change in hours affects your eligibility for benefits under this Plan or a Component Benefit Plan or your spouse’s or dependent’s eligibility under a benefit plan of their employer;
  - (iv) One of your dependents satisfies, or ceases to satisfy, the eligibility requirements for a dependent under a Component Benefit Plan; and/or
  - (v) A change in residence for yourself, your spouse, or your dependent if it affects that person’s eligibility for benefits.

Whether an Election change is consistent with the “change in status” will be determined by the Plan Administrator in accordance with IRS Regulations and prevailing IRS guidance.

- (2) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 ( “HIPAA”), group health plans must provide a “special enrollment” period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth, or adoption. These individuals also include individuals who become eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state’s children’s health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your “special enrollment” rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Unlike with the other election change events, you have 60 days to enroll an individual if the election change event is a HIPAA special enrollment right related to eligible for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.
- (3) *Change in Coverage of Your Spouse or Dependent.* If there is a change in the coverage of your spouse or your dependent and that coverage is obtained through the cafeteria plan of another employer, you may make a “corresponding” Election change. For this exception to apply, one of the following conditions must be met: (i) The plan year of the other employer’s cafeteria plan is different than the Plan Year of this Plan; or (ii) the cafeteria plan of the other employer permits only those election changes that are authorized under IRS regulations. The Plan Administrator will decide in its discretion and in accordance with prevailing IRS guidance whether a requested change is on account of and corresponds with the change made under the plan of the other employer.

*EXAMPLE:* You have elected to provide medical coverage for your family under the Employer’s Medical Plan. Your spouse is employed by a different employer. During open enrollment for the cafeteria plan of that employer, your spouse elects “family coverage” under the medical plan of that employer. The plan year of that employer is different than the plan year of your Employer. Under this exception, you may discontinue your Election to pay for family coverage on a pre-tax basis through this Cafeteria Plan.

- (4) *“Significant” Curtailment in Coverage.*
- (i) *Cessation or Significant Curtailment in Coverage.* If coverage under a plan is “significantly curtailed,” but not lost, you may change your Election to elect coverage under another benefit option that provides similar coverage. Coverage under a plan is “significantly curtailed” only if there is an overall reduction in the coverage provided to participants in the plan. If coverage under a plan is “significantly curtailed” and that curtailment constitutes a “loss of coverage” for you, your spouse, or your dependent, you may change your Election to elect coverage under another benefit option that provides similar coverage. If no similar benefit option is available, you may elect to drop coverage. For purposes of this provision, a “loss of coverage” means a complete loss of coverage under the benefit option. This includes the elimination of a benefit option, the loss of coverage under an option due to an individual reaching an overall lifetime or annual coverage limit, a substantial decrease in the medical care providers available under the option, or a reduction in the benefits for a specific type of medical condition or treatment for which you, your spouse, or your dependent is currently receiving treatment.
  - (ii) *Determinations to be Made by the Plan Administrator.* The Plan Administrator will decide in its discretion, and in accordance with prevailing IRS guidance, whether a curtailment is “significant,” whether a curtailment represents a “loss of coverage” with respect to a particular individual, and whether a substitute benefit option provides “similar coverage.”
- (5) *Addition or Elimination of a Benefit Option.* If a benefit option is added in the middle of a Plan Year or if coverage under an existing benefit option is eliminated, you may make an Election change to add that option.
- (6) *FMLA Leave.* If you take a leave of absence under the FMLA, you may change your Election for coverage under a group health plan. You may also be able to change your Election under the “change in status” exception discussed above.
- (7) *To Comply with a Judgment, Decree or Order.* If you are required to provide medical coverage for a dependent child pursuant to a judgment, decree or order, you may change your Election to pay for the increased cost of the coverage. If you are already providing coverage and a judgment, decree or order requires someone else to provide coverage, you may change your Election to reflect the decreased cost of coverage. *However*, before you are allowed to drop coverage, you may be required to provide proof that other coverage for the child is actually being provided.

- (8) *Entitlement to Medicare / Medicaid.* If you, your spouse, or your dependent becomes entitled to Medicare or Medicaid, you may change your Election to reflect the decreased cost of coverage under the employer's group health plan. If you, your spouse, or your dependent loses your/their entitlement to Medicare or Medicaid, you may increase your Election to reflect the increased cost of coverage under the employer's group health plan.
- (9) *Significant Change in Cost of Coverage.* If your share of the premium for coverage under a benefit option increases by a significant amount, you may increase your Election to reflect the increased cost or you may elect to be covered under another benefit option (if any) providing similar coverage. If similar coverage is not available, you may drop your coverage altogether.

Whether there has been a "significant" change in cost and whether another benefit option provides "similar coverage" will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

In addition to the Election changes which you may make in the middle of a Plan Year, as summarized above, the Plan Administrator may automatically change the amount of your Election in the middle of a Plan Year if there is an "insignificant" change in the cost of the coverage you have elected. Whether there has been an "insignificant" change in cost will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

(e) *Effective Date of Elections.*

- (1) *Election Made During Annual Enrollment Period.* An Election made during the Annual Enrollment Period will be given effect as of the first day of the next Plan Year.
- (2) *Election Made in the Middle of a Plan Year.* An Election made in the middle of a Plan Year will be given effect as of the earliest administratively practicable date after a completed Election Change Form is received by the Plan Administrator. This includes both Election changes and the initial Elections made by new Participants. Under IRS regulations, elections cannot be given retroactive effect. For example, although you can use pre-tax dollars to pay for future coverage, you cannot use pre-tax dollars to pay for coverage that has already been provided. The only exception to this prohibition is for newborn children and newly adopted dependents who are enrolled in a group health plan pursuant to HIPAA "special enrollment" rights. Coverage that is retroactive to the date of their birth or adoption may be paid for on a pre-tax basis.

(f) *Special Rule for Former Participants Rehired Within 30 Days of Termination.* If you are rehired within thirty (30) days after the date on which your employment was terminated, you will be reinstated in the Plan with the same Elections you had before your employment was terminated unless (1) you would be permitted to make an Election change for some reason other than the change in your employment with the Employer or (2) the Plan Year ended on or after the date your employment was terminated but before the date you were rehired.

(g) *Special Rule for Health FSA's.* You may *not* change your Election under the Health Flexible Spending Account Plan ("Health FSA") in the middle of a Plan Year except as follows:

- (1) You may cease to participate in the Health FSA by changing your Election to zero, *if* you are permitted to make an Election change under the rules summarized in Section (3)(d) above;

- (2) You may begin to participate in the Health FSA for the remainder of the Plan Year if you are newly eligible to become a participant in the Health FSA;
- (3) You may begin to participate in the Health FSA for the remainder of the Plan Year if you are not currently participating in the Health FSA, have not previously participated in the Health FSA during the current Plan year, and are permitted to make an Election change under the rules summarized in Section 3(d) above; or
- (4) You may change your Election if the change is made in connection with FMLA leave. The impact of FMLA leave on the Health FSA is summarized in more detail in Section 9(d) below.

Except as set forth above, an Election with respect to the Health FSA may not be changed during the Plan Year once it has been made.

#### **(4) Employee Group Medical Plan**

The Employer maintains an Employee Group Medical Plan ("Medical Plan") pays benefits under an insurance contract with Preferred Health Systems ("PHS"), 8535 E. 21<sup>st</sup> Street North, Wichita, KS 67206.

- (a) *Type of Plan.* The Medical Plan is a Group Health Plan. The Medical Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Dates.* The eligibility conditions and the Plan entry dates are the same as those for the Cafeteria Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Medical Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Plan entry date. **If you do not elect to participate in the Medical Plan, you will not receive any benefits under the Medical Plan.**
  - (1) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Medical Plan until the next Annual Enrollment Period and your enrollment will not take effect until the first day of the next Plan Year. The same rule applies if you fail to enroll your dependents (including your spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.
  - (2) *HIPAA "Special Enrollment" Rights.* If you are declining enrollment in the Medical Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Medical Plan if you request enrollment within 30 days after your other coverage ends. 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, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. Further, if you and/or your dependents become eligible for a state premium assistance subsidy under this Medical Plan from Medicaid or a state's children's health insurance program ("SCHIP"), the individual must be allowed to enroll in the Medical Plan, provided that you request enrollment within sixty (60) days. Finally, if you and/or your dependents lose eligibility for SCHIP or Medicaid, then you will be permitted to enroll in the Medical Plan, provided you are otherwise eligible for coverage and you request enrollment within sixty (60) days.

- (d) *Plan Benefit.* If you elect to participate in the Medical Plan, you will be insured under a benefit description issued by PHS. This policy provides you and/or your dependents with comprehensive medical coverage. PHS has prepared materials which explain the benefits of the group contract in detail. If you have not received these materials from PHS, you should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.
- (e) *Obligation to Pay Benefit.* PHS is solely obligated to pay for medical benefits provided under the PHS group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Medical Plan are determined by PHS and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Cafeteria Plan.
- (g) *Medical Treatment.* The Medical Plan does not provide medical treatment or give medical advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate medical treatment.** The fact that some expense may not be eligible for reimbursement by the Medical Plan does not mean that you or your dependents should not have that treatment.
- (h) *Loss of Benefits.* You will no longer be entitled to benefits under the Medical Plan if the Plan is terminated, if you are no longer eligible to participate in this Plan, or if you fail to pay your share of the premiums for coverage under this Plan. However, if this happens, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this Summary Plan Description.
- (i) *Claims Procedures.* In the event you have a claim for benefits under the Medical Plan, you should follow the procedures outlined in the materials prepared by PHS as applicable. The Plan Administrator, upon your request, will assist you in making these claims. PHS is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the applicable group contract.

## (5) Prescription Drug Plan

The Employer maintains a Prescription Drug Plan that pays benefits pursuant to the terms and conditions of a group insurance contract with Serve You, 10201 Innovation Drive, Suite 600, Milwaukee, WI 53226.

- (a) *Type of Plan.* The Prescription Drug Plan is a self-funded group health plan. The Prescription Drug Plan is funded and administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Dates.* The eligibility conditions and the Prescription Drug Plan entry dates are the same as those for the Cafeteria Plan.
- (c) *Enrollment in the Plan.* **To become a Participant in the Prescription Drug Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Prescription Drug Plan entry date. **If you do not elect to participate in the Prescription Drug Plan, you will not receive any benefits under the Prescription Drug Plan.**

- (1) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Prescription Drug Plan until the next Annual Enrollment Period and your enrollment will not take effect until the first day of the next Plan Year. The same rule applies if you fail to enroll your dependents (including your spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA “Special Enrollment” rights.
- (2) *HIPAA “Special Enrollment” Rights.* If you are declining enrollment in the Prescription Drug Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Prescription Drug Plan if you request enrollment within thirty (30) days after your other coverage ends. 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, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption. Further, if you and/or your dependents become eligible for a state premium assistance subsidy under this Prescription Drug Plan from Medicaid or a state’s children’s health insurance program (“SCHIP”), the individual must be allowed to enroll in the Prescription Drug Plan, provided that you request enrollment within sixty (60) days. Finally, if you and/or your dependents lose eligibility for SCHIP or Medicaid, then you will be permitted to enroll in the Prescription Drug Plan, provided you are otherwise eligible for coverage and you request enrollment within sixty (60) days.
- (d) *Plan Benefits.* If you elect to participate in the Prescription Drug Plan, benefits will be provided by the Employer pursuant to the terms and conditions of a benefit description between the Employer and Serve You. This Prescription Drug Plan provides you and/or your dependents with comprehensive prescription drug coverage. Serve You has prepared materials which explain the benefits provided under this Prescription Drug Plan in detail. If you have not received these materials from Serve You, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.
- (e) *Obligation to Pay Benefits.* Serve You is solely obligated to pay for the benefits provided under the Serve You benefit description. The Employer makes no promise and will have no obligation to provide or pay for benefits under the benefit description.
- (f) *Premiums.* The monthly premiums for insurance coverage under the Prescription Drug Plan are determined by the Employer, and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period.
- (g) *Prescription Drug Treatment.* The Prescription Drug Plan does not provide prescription drug treatment or give prescription drug advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate prescription drug treatment.** The fact that some expense may not be eligible for reimbursement by the Prescription Drug Plan does not mean that you or your dependents should not have that treatment.
- (h) *Claims Procedures.* In the event you have a claim for benefits under the Prescription Drug Plan, you should follow the procedures outlined in the materials prepared by Serve You and the claims procedures in Section (13) of this SPD. The Plan Administrator, upon your request, will assist you in making these claims. Serve You is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

(i) *Termination of Coverage.* Your participation in the Prescription Drug Plan ends on whichever of the following dates occurs first:

- (1) The last day of the month in which you terminate your employment with the Employer;
- (2) The date on which your election to participate expires;
- (3) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
- (4) The last day of the month in which you cease to be an eligible employee; or
- (5) The date the Employer terminates the Prescription Drug Plan.

Your coverage for benefits under the Prescription Drug Plan ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this SPD.

### **(6) Health Flexible Spending Account Plan**

The Employer maintains a Health FSA that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The Health FSA is a self-funded group health plan. The Health FSA is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility.* The eligibility conditions are the same as those for the Cafeteria Plan.

(c) *Election to Participate in the Plan.* To become a Participant in the Health FSA, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the Health FSA, the Employer will not provide you with any benefits under the Health FSA.**

(1) *Failure to Enroll When First Eligible.* As a general rule, if you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Health FSA until the next Annual Enrollment Period, in which case your enrollment will not take effect until the first day of the next Plan Year. However, if you experience an event that would allow an Election change under the terms of the Cafeteria Plan (see Section 3(d) of this SPD) and you have not previously enrolled in the Health FSA, you may enroll in the Health FSA in the middle of the Plan Year.

(2) *Election Changes Once Enrolled in the Health FSA.* Once you elect to participate in the Health FSA, you will not be permitted to change your Election in the middle of the Plan Year. For example, you will not be allowed to change your Election from one dollar amount to another dollar amount during the middle of a Plan Year. However, some Election changes are permitted if they are made in connection with FMLA leave. This exception is summarized in more detail below.

(d) *Special Rules Relating to FMLA Leave.* If you are a Participant in the Health FSA and you are taking or returning from FMLA leave, the following special rules apply to your participation in the Health FSA:

- (1) *Taking FMLA Leave.* You may continue to participate in the Health FSA after you begin your FMLA leave by continuing to pay the applicable premium while you are on leave or by making such other arrangements for the payment of the applicable premiums as may be permitted under the Cafeteria Plan (see Section 12(b) of this SPD). You may also choose to discontinue your participation in the Health FSA once you begin your FMLA leave.
  - (2) *Returning From FMLA Leave.* If you discontinued your participation in the Health FSA when you began your FMLA leave, you may choose to participate again once you return to work from your FMLA leave. If you want to resume your participation at the same coverage level that was in effect before your FMLA leave, you will be required to pay the premiums that would have been due while you were on FMLA leave. If you do not want to make up the missed premiums, you may instead choose to resume coverage at a reduced level. In this event, the amount of coverage that you elected will be reduced by the percentage of the Plan Year that you were on FMLA leave. For example, if you had elected \$1,200 for the Plan Year and were on FMLA for two months, your annual Election would be reduced to \$1,000 under this alternative.
- (e) *Plan Entry Dates.* If you elect to participate in the Health FSA, your Election will take effect and you will become a Participant as follows:
- (1) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Cafeteria Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a participant as of the first day of the next plan year.
  - (2) *Election Made by A Newly Eligible Employee.* If you elect to participate within thirty (30) days after you first become eligible to participate in this Health FSA, your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.
- EXAMPLE.* You begin working as a full-time employee on January 15. You complete one (1) day of employment with the Employer on January 16. If you wish to participate in the Health FSA, you must make an Election to do so within thirty (30) days of January 16, (that is, by February 15).
- Your plan entry date, in this example, will depend on the date your completed Election form is received. If it is received on or before February 15, you will enter the Plan on February 15. If your Election form is received after February 15 but no later than March 1, you will enter the Plan on March 1.
- If you do not return a completed Election form, or if your completed Election form is received after March 1, you will not be able to enter the Health FSA until March 1 of the following year unless you experience an “Election change event” (see below).
- (3) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Cafeteria Plan (see Section 3(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

*EXAMPLE* . During the Annual Enrollment Period, you did not elect to participate in the Plan. On April 15, your child is born. This is a “change in status” which allows you to make an Election change under the Cafeteria Plan. You may elect to participate in this Plan if you do so within thirty (30) days after April 15, (that is, by May 14). If you do not elect to enter the Health FSA within thirty (30) days after this “change in status,” you will not have a second opportunity to enter the Health FSA until the first day of the next Plan Year unless you experience a second Election change event.

- (f) *Plan Benefits*. If you elect to participate in the Health FSA, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. To determine how much you should reduce your salary for medical reimbursement benefits, you should estimate the amount of medical and dental expenses you expect to have for the Plan Year in which your health or dental insurance will not cover. When you incur uninsured medical or dental expenses, the Plan Administrator will reimburse you for those expenses. The amount of salary you reduce for these medical or dental expenses is not subject to income tax or FICA.

*EXAMPLE: You elect to reduce your salary by \$1,200 for the Plan Year. Therefore, \$1,200 is your maximum reimbursement for uninsured medical expenses incurred for that Plan Year.*

**If you do not incur uninsured medical expenses for the Plan Year equal to the maximum reimbursement amount, you will lose the unused portion.**

*EXAMPLE: Assume you elect to reduce your salary by \$1,200 for medical expenses, but incur only \$1,000 of uninsured expenses for the Plan Year. As required by IRS regulations, you will forfeit the remaining \$200. This example illustrates the importance of carefully estimating your uninsured medical expenses for the Plan Year.*

- (g) *Maximum Benefit Amount*. Under the Health FSA, the maximum amount of reimbursement for a Plan Year is \$3,000 or the actual amount of your salary reduction for the Plan Year, whichever is less. If you or your dependents incur a “qualified medical expense,” you will receive a reimbursement for the portion of that expense not covered by health or dental insurance, but no more than this maximum amount. The Plan Administrator will determine your maximum reimbursement amount on the basis of the total amount of salary you have elected to reduce for the Plan Year under the Health FSA, even if you incur the expense before the end of the Plan Year.
- (h) *Qualified Medical Expenses*. The “qualified medical expenses” for which you (or your spouse or “dependent,” as defined in Section 152 of the Internal Revenue Code, without regard to subsections (b)(1), (b)(2), or (d)(1)(B) and to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than one-half their support for the calendar year from one or both parents and are in the custody of one or both parents for at least one-half of the calendar year)) are entitled to reimbursement under the Health FSA are generally those medical expenses that are tax deductible under Section 213(d) of the Internal Revenue Code and for which you have not otherwise been reimbursed through insurance or any other means. Typical expenses include, but are not limited to:

- (1) Deductibles and copayment amounts you pay under your medical or dental or vision care coverage;

- (2) Medical, dental and/or vision care expenses in excess of usual, reasonable and customary rates; and
- (3) Any other Code § 213(d) medical, dental, or vision expenses not reimbursed by insurance; provided, however, over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription are not eligible for reimbursement as “qualified medical expenses.”

The Health FSA does not reimburse for amounts paid to obtain other health insurance coverage. The Health FSA will only reimburse you for qualified medical expenses incurred while you are a Participant in the Health FSA. Under Internal Revenue Service rules, a qualified medical expense is generally considered to be “incurred” when the treatment is provided and not when you are billed for the treatment or when the treatment is paid for.

Typical expenses not eligible for reimbursement by the Health FSA include, but are not limited to:

- (1) Those reimbursed through any other policy or plan, including Medicare or other Federal programs;
  - (2) Those incurred before you enroll in the Health FSA;
  - (3) Those incurred in any year other than the year for which Health FSA contributions are made;
  - (4) Those claimed as a deduction or credit for Federal income tax purposes; and,
  - (5) Those the IRS would not allow as deductions for Federal income tax purposes, except for certain over-the-counter drugs.
- (i) *How to Submit a Claim.* In the event you have a claim for benefits under the Health FSA, you should submit a claim using the claims form that will be provided to you by the Plan Administrator and following the instructions on that form. The Claims Administrator may require you to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:
- (1) The amount, date incurred and nature of each expense;
  - (2) The name of the person, organization or entity with whom the expense was incurred;
  - (3) The name of the person for whom the expense was incurred;
  - (4) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and
  - (5) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

- (j) *Claims Administrator.* AFLAC will act as Claims Administrator with respect to any claims for benefits under this Health FSA Plan. AFLAC is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.
- (k) *Timing of Claims.* You may make your claim for benefits for expenses incurred during any Plan Year only against your accounts for that Plan Year. You may submit your claim for benefits under the Health FSA Plan during the Plan Year in which incurred or within the ninety (90) day period after February 28 of each Plan Year. If you terminate your participation in the Health FSA or if the Employer terminates the Health FSA Plan, you must submit your claim for reimbursement for that Plan Year through the end of the Plan Year for claims dated prior to your termination date. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than February 28 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.
- (l) *Time Frame for Deciding Claims.* If any claim for benefits under this Health FSA is denied, in whole or in part, then the Claim Administrator will promptly furnish you, within thirty (30) days of receipt of the claim, written notice:
  - (1) Setting forth the reason for the denial;
  - (2) Making reference to pertinent Health FSA provisions upon which the denial is based;
  - (3) Describing any additional material or information which is necessary and why;
  - (4) Referencing any internal rule, guideline, or protocol, or similar criterion relied upon in making the adverse determination (if applicable); and
  - (5) Explaining the claim review procedure set forth herein, including applicable time limits.
- (m) *Extension of Time Frame for Deciding Claims.* The Claim Administrator may seek one extension of up to fifteen (15) days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan. You will be notified of the extension prior to the expiration of the initial thirty (30) day period. If the extension is due to your failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and give you at least forty-five (45) days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which you responds to the request for information.
- (n) *Appealing a Claim Denial.* If your claim is denied, in whole or in part, you have one hundred and eighty (180) days to submit an appeal. You may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.
- (o) *Time Frame for Deciding Appeal.* The Plan Administrator shall render a decision on review no later than sixty (60) days after receipt of your request for review unless special circumstances require an extension of time (not to exceed 60 days from the date of the initial 60-day period). You will be furnished with written notice of any such extension.

- (p) *Decision on Appeal.* In conducting the review, no deference will be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the claim (or the person's subordinate), will make the determination upon appeal. The decision on review shall be in writing. If the claim is once again denied, in whole or in part, then the notification shall (1) state the reason for the decision, (2) refer to the Health FSA provisions upon which it is based, (3) state your right to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information and (4) describe any voluntary appeals procedures.
- (q) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services. Prior to making any payment of benefits under the Health FSA, AFLAC (or the Plan Administrator) may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. AFLAC and/or the Plan Administrator may rely upon all such information furnished to it, including your current mailing address. Furthermore, AFLAC (or the Plan Administrator), prior to making payments under the Plan, may request you file all appropriate claims and requests for payment from any other plan or plans maintained by the Employer, including requests for payment with any insurance carrier which has the responsibility for making any benefit payments under any plans maintained by the Employer.

#### (7) Dependent Care Assistance Plan

The Employer maintains a DCAP that pays benefits out of the Employer's general assets.

- (a) *Type of Plan.* The DCAP is a Code Section 129 dependent care assistance plan. The DCAP is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility.* The eligibility conditions are the same as those for the Cafeteria Plan.
- (c) *Election to Participate in the Plan.* To become a Participant in the DCAP, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the DCAP, the Employer will not provide you with any benefits under the DCAP.**
- (d) *Plan Entry Dates.* If you elect to participate in the DCAP, your Election will take effect and you will become a Participant as follows:
  - (1) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Cafeteria Plan, your Election will take effect on the first day of the next Plan Year. In other words, you will become a participant as of the first day of the next plan year.
  - (2) *Election Made by A Newly Eligible Employee.* If you elect to participate within thirty (30) days after you first become eligible to participate in this DCAP, your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

*EXAMPLE.* You begin working as a full-time employee on April 15. You complete one (1) day of employment with the Employer on April 16. If you wish to participate in the DCAP, you must make an Election to do so within thirty (30) days of April 16, (that is, by May 15).

Your plan entry date, in this example, will depend on the date your completed Election form is received. If it is received on or before April 15, you will enter the Plan on May 1. If your Election form is received after April 15 but no later than May 15, you will enter the Plan on June 1.

If you do not return a completed Election form, or if your completed Election form is received after May 15, you will not be able to enter the DCAP until March 1 of the following year unless you experience an “Election change event” (see below).

- (e) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Cafeteria Plan (see Section 3(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

*EXAMPLE.* During the Annual Enrollment Period, you did not elect to participate in the Plan. On April 15, your spouse begins a full time job. This is a “change in status” which allows you to make an Election change under the Cafeteria Plan. You may elect to participate in this Plan if you do so within thirty (30) days after April 15, (that is, by May 14). If you do not elect to enter the DCAP within thirty (30) days after this “change in status,” you will not have a second opportunity to enter the DCAP until March 1 of the following year unless you experience a second Election change event.

- (f) *Plan Benefits.* If you elect to participate in the DCAP, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. Under the DCAP, the maximum amount of reimbursement you may receive for a Plan Year is limited to the actual amount of your salary reduction for the Plan Year.
- (g) *Maximum Benefit Amount.* The benefits you receive under this DCAP may not exceed the maximum amount specified in the Internal Revenue Code. The maximum amount specified in the Internal Revenue Code is \$5,000 (or \$2,500 if you are a married person filing a separate return) or, if less, your “earned income limitation.” The “earned income limitation” is your earned income, if you are not married. If you are married, the earned income limitation is the lesser of your earned income or your spouse's earned income.
- (h) *IRS “Use It or Lose It” Requirement.* You should carefully evaluate the amount of your salary reduction for dependent care expenses. ***If your dependent care expenses are less than the amount by which you have reduced your salary for the Plan Year, you will forfeit the excess amount.*** This is an IRS requirement.
- (i) *Election Changes.* Once you make an Election to participate in this DCAP, that Election may not be changed in the middle of the Plan Year, either as to your participation in this Plan or as to the dollar amount you elected, unless an Election change is permitted under the terms of the Cafeteria Plan (see Section 3(d) of this SPD).

(j) *Federal Income Tax Considerations.* You may be able to claim a Dependent Care Tax Credit on your federal income tax return for your dependent care expenses. The availability of this credit depends on the number of dependents you have and your gross income. More information about the federal Dependent Care Tax Credit may be found in IRS Publication No. 503. ***You may not claim a credit on your federal income tax return for any dependent care expenses for which you have been reimbursed by the DCAP.*** In many cases, you may save more money by receiving tax-free reimbursements under this Plan than by claiming the tax credit. ***Consult your own tax advisor if you are in doubt as to whether to obtain reimbursements under the Plan or to take the tax credit.***

(k) *Qualified Dependent Care Expenses.* A dependent care expense is an amount paid by you for the care of a qualified dependent, including related household services, which enables you to be gainfully employed. The “qualified” dependent care expenses for which you are entitled to reimbursement under the DCAP are generally those dependent care expenses that are permitted under Section 129 of the Internal Revenue Code.

(1) *Qualified Dependent.* A qualified dependent is:

(i) Your child (as defined in Internal Revenue Code § 152) who is under age 13 and is your “qualifying child” as defined in Code § 152(a)(1); or

(ii) Your tax dependent as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2), and (d)(1)(B), who:

A. Is physically or mentally incapable of caring for himself/herself; and

B. Is living with you for more than one-half of the calendar year.

(iii) Your spouse who is physically or mentally incapable of self-care and who is living with you for more than one-half of the calendar year.

If you are divorced or separated and have a child whom you do not claim as a dependent for Federal income tax purposes, the child must be in your custody for at least six (6) months out of the year to be a qualified dependent.

(2) *Types of Expenses Eligible For Reimbursement.* The following expenses are eligible for reimbursement:

(i) Payments for the care of a qualified dependent in your home. This includes care provided by a babysitter, nurse or housekeeper in your home, as long as part of their service benefits the qualified dependent.

(ii) Payments for the care of a qualified dependent outside your home. If such expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six (6) individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations.

(iii) Pre-school care, before and after-school care and day camp during school vacation.

- (3) *Types of Expenses Not Eligible For Reimbursement.* The following expenses are not eligible for reimbursement:
- (i) Expenses paid through another policy or plan providing dependent care benefits to you or your spouse.
  - (ii) Amounts paid to your child who is age eighteen (18) or younger for babysitting or care of a qualified dependent.
  - (iii) Expenses paid to a person whom you or your spouse are entitled to claim as a dependent for Federal income tax purposes.
  - (iv) Expenses incurred prior to becoming a Participant in the DCAP.
  - (v) Education expenses for a child in kindergarten or any higher grade.
  - (vi) Overnight care at a convalescent nursing home for a dependent spouse or relative.
  - (vii) Overnight camp.
  - (viii) Expenses for lessons, tutoring or certain types of transportation expenses.
  - (ix) Forfeited deposits, but may include application fees, agency fees, and deposits if you are required to pay the expenses to obtain dependent care.
- (1) *Claims Procedures.* In the event you have a claim for benefits under the DCAP, you should submit a claim using the claim form that will be provided to you by the Claims Administrator and follow the instructions on that form.
- (1) *Claims Administrator.* The Employer has designated AFLAC to act as the Claims Administrator for the DCAP. As the Claims Administrator, AFLAC shall have the sole authority to grant or deny any claims for benefits under this Plan. If the Claims Administrator denies a claim, it will state its denial in writing and will deliver or mail to the Participant a notice of denial of benefits, setting forth the specific reasons for the denial. In addition, the Claims Administrator will give any Participant whose claim for benefits has been denied a reasonable opportunity for a review of the decision denying the claim.
- (2) *When to Submit a Claim.* You may submit your claim for reimbursement for expenses you incurred during the Plan Year in which incurred or within the ninety (90) day after February 28 of each Plan Year. If you terminate your participation in the DCAP or if the Employer terminates the DCAP, you must submit your claim for reimbursement for that Plan Year through the end of the Plan Year for claims dated prior to your termination date. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than February 28 of that Plan Year to receive reimbursement for expenses covered by the plan which you incurred prior to that July 1.

- (3) *Claims Decisions and the Right to Appeal.* Within a reasonable time, not exceeding ninety (90) days (unless the Claims Administrator notifies you of an extension of up to ninety (90) days), the Claims Administrator will inform you of its decision to approve or deny your claim. If the Claims Administrator denies your claim, in whole or in part, you may have a right to appeal the decision.
- (4) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services.
- (5) *Information Regarding Claims.* Prior to making any payment of benefits under the DCAP, the Claims Administrator may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. The Claims Administrator may rely upon all such information furnished to it, including your current mailing address.

### **(8) Employee Group Vision Plan**

The Employer maintains an Employee Group Vision Plan ("Vision Plan") that pays benefits under insurance contracts with Vision Service Plan Insurance Company (VSP), 3333 Quality Drive, Rancho Cordova, CA 95670 and Vision Care Direct, 2178 South 900 East, Ste. 6, Salt Lake City, UT 84106.

- (a) *Type of Plan.* The Vision Plan is a Group Health Plan. The Vision Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Dates.* The eligibility conditions and the Plan entry dates are the same as those for the Cafeteria Plan, except a participant's regularly scheduled workweek must ordinarily equal or exceed thirty (30) hours per week.
- (c) *Enrollment in the Plan.* **To become a Participant in the Vision Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your Plan entry date. **If you do not elect to participate in the Vision Plan, you will not receive any benefits under the Vision Plan.**
  - (1) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the Vision Plan until the next Annual Enrollment Period and your enrollment will not take effect until the first day of the next Plan Year. The same rule applies if you fail to enroll your dependents (including your spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.
- (d) *Plan Benefit.* If you elect to participate in the Vision Plan, you will be insured under a group contract issued by VSP or Vision Care Direct. This policy provides you and/or your dependents with comprehensive vision coverage. VSP or Vision Care Direct has prepared materials which explain the benefits of the group contract in detail. If you have not received these materials from VSP or Vision Care Direct, you should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.
- (e) *Obligation to Pay Benefit.* VSP or Vision Care Direct is solely obligated to pay for the benefits provided under the group contract. The Employer makes no promise and will have no obligation to provide or pay for benefits under the group contract.

- (f) *Premiums.* The monthly premiums for insurance coverage under the Vision Plan are determined by VSP or Vision Care Direct and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Cafeteria Plan.
- (g) *Vision Treatment.* The Vision Plan does not provide vision treatment or give vision advice. **It is your responsibility, in consultation with the physicians of your choice, to get appropriate vision treatment.** The fact that some expense may not be eligible for reimbursement by the Vision Plan does not mean that you or your dependents should not have that treatment.
- (h) *Loss of Benefits.* You will no longer be entitled to benefits under the Vision Plan if the Plan is terminated, if you are no longer eligible to participate in this Plan, or if you fail to pay your share of the premiums for coverage under this Plan. However, if this happens, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate section of this Summary Plan Description.
- (i) *Claims Procedures.* In the event you have a claim for benefits under the Vision Plan, you should follow the procedures outlined in the materials prepared by VSP or Vision Care Direct. The Plan Administrator, upon your request, will assist you in making these claims.

#### **(9) AFLAC Pre-Tax Plan**

The Employer maintains the AFLAC Pre-Tax Plan that permits Participants to elect to receive benefits under one or more individual policies of insurance issued by American Family Life Assurance of Columbus (“AFLAC”), 1932 Wynnton Road, Columbus, Georgia 31999.

- (a) *Type of Plan.* The AFLAC Pre-Tax Plan is administered by the Employer; however, benefit claims are processed by the Claims Administrator.
- (b) *Eligibility / Plan Entry Date.* The eligibility conditions and the AFLAC Pre-Tax Plan entry date are the same as those for the Cafeteria Plan, except a participant’s regularly scheduled workweek must ordinarily equal or exceed thirty (30) hours per week.
- (c) *Enrollment in the Plan.* **To become a Participant in the AFLAC Pre-Tax Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your AFLAC Pre-Tax Plan entry date. **If you do not elect to participate in the AFLAC Pre-Tax Plan, you will not receive any benefits under the AFLAC Pre-Tax Plan.**
- (d) *Plan Benefits.* If you elect to participate in the AFLAC Pre-Tax Plan, you will be able to select from the following individual policies of insurance which are issued by AFLAC:
  - (1) Cancer Plan;
  - (2) Personal Accident Plan;
  - (3) Personal Recovery Plus Plan; and/or
  - (4) Personal Intensive Care Plan.

These individual policies provide you (and your dependents, if family coverage is selected) with various types of insurance. AFLAC has prepared materials which explain the benefits of each individual policy in detail. AFLAC will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this Summary Plan Description.

- (e) *Obligation to Pay Benefits.* AFLAC is solely obligated to pay for the benefits provided under the AFLAC Pre-Tax Plan. The Employer makes no promise and will have no obligation to provide or pay for benefits under the AFLAC Pre-Tax Plan.
- (f) *Premiums.* The monthly premiums for insurance coverage under the various individual policies listed in (d) above are determined by AFLAC and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay 100% of the monthly premium cost. Premiums may be paid on a pre-tax basis through the Cafeteria Plan.
- (g) *Claims Procedures.* In the event you have a claim for benefits under the AFLAC Pre-Tax Plan, you should follow the procedures outlined in the materials prepared by AFLAC as applicable. The Plan Administrator, upon your request, will assist you in making these claims. AFLAC is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract.
- (h) *Termination of Coverage.* Your participation in the AFLAC Pre-Tax Plan ends on whichever of the following dates occurs first:
  - (1) The last day of the month in which you terminate your employment with the Employer;
  - (2) The date on which your election to participate expires for the applicable policy or policies;
  - (3) The end of a period in which you last paid a required contribution, taking into account any grace periods required by law;
  - (4) The last day of the month in which you cease to be an eligible employee; or
  - (5) The date the Employer terminates the AFLAC Pre-Tax Plan.

Your coverage for benefits under the AFLAC Pre-Tax Plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by AFLAC. Please refer to the individual policies for further details.

#### **(10) COBRA Coverage for Group Health Plans**

COBRA coverage is a temporary extension of coverage under group health plans under certain circumstances when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you and to other members of your family who are covered under the group health plans when group health coverage would otherwise be lost. **This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The group health components of the Plan in which you may be enrolled are the Medical Plan, Prescription Drug Plan, Vision Plan and the Health FSA. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires and nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

- (a) *Qualified Beneficiary.* After a qualifying event (described below) occurs and any required notice of that event is properly provided to the Employer, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under a group health plan is lost because of the qualifying event. (Certain newborns, newly-adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)
  
- (b) *Continuation Coverage.* Continuation coverage is the same coverage that the group health plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the group health plan as other participants or beneficiaries covered under the plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
  
- (c) *Qualifying Events.* COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events with respect to each type of qualified beneficiary are as follows:
  - (1) *Employee.* If you are an employee, you will become a qualified beneficiary if you lose (or will lose) your group health coverage under the Plan because either one of the following qualifying events happens:
    - (i) Your hours of employment are reduced; or
    - (ii) Your employment ends for any reason other than for gross misconduct.
  
  - (2) *Spouse.* If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:
    - (i) Your spouse dies;
    - (ii) Your spouse's hours of employment are reduced;
    - (iii) Your spouse's employment ends for any reason other than for gross misconduct;
    - (iv) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
    - (v) You become divorced or legally separated from your spouse. If your spouse (the employee) reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

- (3) *Dependents.* If you are the covered dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:
- (i) Your parent-employee dies;
  - (ii) Your parent-employee's hours of employment are reduced;
  - (iii) Your parent-employee's employment ends for any reason other than for gross misconduct;
  - (iv) Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
  - (v) Your parents become divorced or legally separated; or
  - (vi) You stop being eligible for coverage under the plan as a "dependent child."

In addition to the above qualifying events, filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

- (d) *FMLA Leave.* If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the group health plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.
- (e) *Trade Adjustment Assistance.* Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period last for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within six months immediately after the individual's group health plan coverage ended. There are also new tax credits for certain individuals who become eligible for TAA and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Employer using the plan contact information found in this SPD.

You must contact the Employer promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information is also available at [www.doleta.gov/tradeact/2002act\\_index.asp](http://www.doleta.gov/tradeact/2002act_index.asp).

- (f) *Special Rule for Health FSAs.* COBRA coverage under a Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if he or she has not been reimbursed more money than he or she has contributed.
  - (1) *COBRA Coverage.* COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year.
  - (2) *Qualified Beneficiaries.* Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. Each beneficiary, however, has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, you should contact the Employer for more information.
- (g) *Notice Procedures.* When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within 60 days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with the procedures outlined in Appendix A to this SPD.**
  - (1) *Forms.* The notice procedures outlined in Appendix A may require that specific forms be used by you in providing proper notice of certain qualifying events to the Plan. The Plan will not provide you with an Election Form to begin or extend COBRA coverage if it does not receive proper notice from you regarding the qualifying events listed in Appendix A.
  - (2) *Failure to Follow Procedures.* **If the procedures outlined in Appendix A are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.**
- (h) *Electing COBRA Coverage.* Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, the covered employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse of a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

(i) *Sixty (60) Day Election Period.* A qualified beneficiary must elect coverage in writing within 60 days of losing coverage under the Plan (or, if later, within 60 days of being provided a COBRA election notice) using the Plan's Election Form and following the procedures specified on the Election Form. (A copy of the Plan's Election Form may be obtained from the Plan Administrator.) The Election Form must be mailed or hand delivered to the address indicated at the beginning of this SPD and as indicated on the Plan's Election Form. If you mail your election, it must be postmarked no later than the last day of the 60-day election period. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

(1) *Failure to Return Election Form.* **If you or your covered spouse or covered dependent children do not elect continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.**

(2) *Rejection of COBRA Rights.* If a qualified beneficiary rejects COBRA before the due date, he or she may change his or her mind as long as a completed Election Form is furnished before the due date.

(3) *Elections Under More-Than-One Group Health Plan.* Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event.

(j) *Consequences of Rejecting COBRA Coverage.* In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law:

(1) *Preexisting Conditions.* If you do not elect COBRA and you have a 63 day or more gap in health coverage, you may have preexisting condition exclusions applied to you by other group health plans. An election of continuation coverage may help you not have such a gap.

(2) *Individual Insurance Policies.* If you do not elect COBRA for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose preexisting condition exclusions.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

(k) *Length of COBRA Coverage.* The COBRA coverage periods described below are *maximum* coverage periods for each type of qualified event. COBRA coverage can end before the end of the maximum coverage periods for several reasons outlined in subsection (l) below.

- (1) *Employee's Termination of Employment.* COBRA continuation coverage may last for up to 18 months for the former employee, the spouse and any dependents who are qualified beneficiaries. The 18-month period for the spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in subsection (l) below.
  - (2) *Employee's Reduction of Hours.* COBRA continuation coverage may last for up to 18 months for the employee, spouse and any dependents who are qualified beneficiaries. The 18-month period for the spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in subsection (l) below.
  - (3) *Death of Employee.* COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
  - (4) *Employee Entitlement to Medicare.* COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
  - (5) *Divorce or Legal Separation.* COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
  - (6) *Loss of Dependent Status.* COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.
  - (7) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA may not be continued beyond the end of the plan year in which the qualifying event occurred.
- (l) *Extension of Maximum Coverage Period (Not applicable to Health FSA).* If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-month period preceding his or her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)
- (1) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61<sup>st</sup> day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

- (2) *Extension Due to a Second Qualifying Event.* An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan if the first qualifying event had not occurred.
- (3) *Medicare Extension for Spouse and Dependents.* If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

**These extensions are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within 30-days of entitlement in accordance with the Plan's notice procedures found in Appendix A.**

- (4) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA will not be extended and will only continue until the end of the plan year in which the initial qualifying event occurred.
- (m) *Termination of COBRA Coverage before End of Maximum Period.* Continuation coverage will be terminated before the end of the maximum period if:
- (1) Any required premium is not paid before the end of the grace period;
  - (2) After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan (but only after any preexisting condition exclusions of that other plan have been exhausted or satisfied for a preexisting condition of the qualified beneficiary);
  - (3) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);
  - (4) The employer ceases to provide any group health plan for its employees;
  - (5) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or
  - (6) Coverage would have been terminated under the same circumstances for a participant or beneficiary not receiving continuation coverage, for example, if a participant or beneficiary engages in fraudulent activities against the Plan.

- (n) *Cost of COBRA Coverage.* Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.
- (o) *First Payment.* All COBRA premiums must be paid by check. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for COBRA coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the address indicated at beginning of this SPD and also on the Election Notice. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

*Example.* You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on November 15. Your initial payment equals the premiums for October and November and is due on or before December 30, which is the 45<sup>th</sup> day after the date of your COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

- (p) *Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the Election Notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

*Example.* You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on October 15. Your initial payment is due on or before November 29<sup>th</sup> and should equal the premium for October. You will be required to make monthly premiums, starting with the month of November, by the first of each month. This means that the premium for November is due by the first of November.

- (q) *Grace Periods.* Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

**If you fail to make a monthly payment before the end of the grace period for that payment/month, you will lose all rights to COBRA coverage under the Plan.**

- (r) *Children Born to or Placed for Adoption.* A child born to, adopted by or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).
- (s) *Alternate Recipients Under QMCSOs.* A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.
- (t) *Address Changes.* In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.
- (u) *Questions.* Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator. For more information about your rights, including COBRA, HIPAA and other laws affecting group health plans, contact the nearest regional or district office the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of regional and district EBSA offices are available through this website.)

***Special Note: The above section only applies if your Employer is required to offer COBRA continuation coverage.*** Generally, your Employer is required to offer COBRA continuation coverage unless the "small employer" exception to COBRA applies. This exception is based on the number of employees that your Employer employed during the previous calendar year. Generally, if such number is *less than twenty (20)*, then your Employer is *not* subject to COBRA and you should disregard this Section. **In the event, however, that your Employer has twenty (20) or more employees as determined under COBRA**, the above Section will apply to an employee covered under a group health plan sponsored by the Employer and to such employee's covered spouse and/or covered dependents. **If COBRA applies, you should read this Section carefully.**

### (11) USERRA Continuation Rights

If you are absent from employment as a result of military service, you shall have the right to elect continuation coverage for a period of up to twenty-four (24) months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

- (a) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than thirty-one (31) days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than thirty (30) days, you must pay the entire cost of coverage plus an additional 2%.
- (b) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

### (12) Recovery of Benefits by the Prescription Drug Plan

- (a) *Subrogation.* The right of subrogation means the right of the Prescription Drug Plan to “step into your shoes” and take over your right to receive payments from third parties or to pursue a cause of action against third parties, to the extent of payments made by the Prescription Drug Plan. By *accepting* benefits from the Prescription Drug Plan, as applicable, you are agreeing to the Prescription Drug Plan’s right of subrogation to any claim or right of action that you may have against a third party. You may be required to sign an agreement affirming this right of the Prescription Drug Plan before any benefits are paid in connection with a particular injury or condition.

*Example of Subrogation:* You are injured in a car accident and the Medical Plan pays your medical expenses resulting from the accident. You have a claim against the other driver for your injuries. The Medical Plan may make a claim against the other driver because either (1) you do not assert a claim against the driver, or (2) you assert a claim against the other driver, but it does not include damages for medical expenses that were paid by the Medical Plan.

- (b) *Reimbursement.* The right of reimbursement is the right of the Prescription Drug Plan to recover from you or your covered Dependent any and all benefits previously paid by the Prescription Drug Plan with respect to an injury or condition when you are compensated for such injury or condition from any source, whether by settlement, judgment, compromise, or otherwise. The right to reimbursement also includes future medical expenses, if any.

By *accepting* benefits under the Prescription Drug Plan, you are agreeing to reimburse the Prescription Drug Plan, as applicable, out of any recovery you might receive from third parties. If you bring a liability claim against any third party, benefits payable under this Prescription Drug Plan must be included in the claim.

You must not do anything which would prejudice the Prescription Drug Plan’s rights of reimbursement, and you may be required to sign and deliver documents reasonably necessary to secure the rights of the Prescription Drug Plan to reimbursement.

*Example of Reimbursement:* You are injured in a car accident and the Medical Plan pays your medical expenses resulting from the accident. You bring a claim against the other driver for your injuries, which you eventually settle against the other driver. The Medical Plan is entitled to immediate reimbursement from what you recovered in your settlement for *all benefits* paid by the Medical Plan in connection with your injuries. You may not reduce the amount owed the Medical Plan in order to account for attorney's fees and costs. Further, the Medical Plan must be paid *first* out of the *total* amount of the settlement.

- (c) *Amount Due.* The amount owed to the Prescription Drug Plan may not be reduced by the attorney's fees and costs incurred in asserting your claim against third parties. In addition, the Prescription Drug Plan's rights of reimbursement and subrogation take precedent over your right to be made whole.
- (d) *Condition of Payment.* At the Prescription Drug Plan's request, you (or your covered Dependent) must take any action, give information, and/or execute instruments required by the Plan, in its discretion, in order to aid the Prescription Drug Plan in its enforcement of its rights of recovery through reimbursement and subrogation. If you (or your covered Dependent) fail to comply with such requests, the Plan may withhold benefits, services, payments, or credits due under the Prescription Drug Plan.

### **(13) Prescription Drug Plan Claims Procedures**

Payment by the Claims Administrator is based on data furnished by you. In order to collect benefits under the Plan, you must first provide the Claims Administrator with information about your claim for benefits.

The specific procedures that apply to your claim will depend on whether your claim is a "Post-Service Claim," a "Pre-Service Claim," or an "Urgent Care Claim." The rules applicable to each of these types of claims are summarized below.

#### **Post-Service Claims**

- (a) *Definition.* A "Post-Service Claim" is a claim that is submitted after the medical care or medical treatment or prescription drug has already been provided.
- (b) *Claims Form.* A Post-Service Claim should be filed using the claims form provided by the Claims Administrator. This form, when completed, contains the essential information necessary to decide on the validity of a claim for benefits. Occasionally, further information may be necessary and you should provide this to the Claims Administrator as requested.
- (c) *Deadline for Filing a Claim.* A Post-Service Claim must be received by the Claims Administrator no later than 12 months after the date on which the Claim was incurred. A Claim that is not filed within this time period will be denied.
- (d) *Deadline for Deciding a Claim.* The Claims Administrator will ordinarily decide a Post-Service Claim within 30 days after it was received. The Claims Administrator may extend this 30 day period for up to an additional 15 days if the extension is necessary due to matters beyond the control of the Plan. You will be notified if the 30 day period is extended.

- (e) *Failure to Submit Necessary Information.* If you do not submit information that is necessary to process a Post-Service Claim, the Claims Administrator will notify you of the failure within 30 days after your Claim is received and will identify the specific information that is necessary to process the Claim. You will have 45 days to provide the additional information. If the additional information is not provided within this time period, the Claim will be denied. If the additional information is provided, the Claims Administrator will decide the Claim within the number of days remaining in the original 30 day period (as extended).
- (f) *Notification Regarding Adverse Benefit Determination.* If a Post-Service Claim is denied, the Claims Administrator will notify you in writing. The notice will explain why the Claim was denied and will provide information about your right to appeal the denial of the Claim.
- (g) *Appealing a Denial.* An appeal of a claims denial must be filed with the Claims Administrator within 180 days after your receipt of a notice of adverse benefit determination. The appeal will be decided by an individual or individuals appointed by the Claims Administrator who were not involved in the original decision to deny the Claim. An appeal will be decided within 60 days after the Claims Administrator's receipt of your request for an appeal. You will be notified in writing of the decision that was reached on appeal. If your appeal was denied, the notice will explain why and will provide additional information about your rights.

### **Pre-Service Claims**

- (a) *Definition.* A Claim is a "Pre-Service Claim" if you are required to obtain advance approval for the underlying medical care or treatment or prescription drug by the Plan's Utilization Review Organization in order to obtain the maximum benefit that is available under this Plan. A Pre-Service Claim does not include "Urgent Care Claims," which are explained below.
- (b) *Claims Form.* A Pre-Service Claim should be filed using the claims form provided by the Claims Administrator. This form, when completed, contains the essential information necessary to decide on the validity of a claim for benefits. Occasionally, further information may be necessary and you should provide this to the Claims Administrator as requested.
- (c) *Deadline for Filing a Claim.* A Pre-Service Claim must be filed before the care or treatment is provided. It should be filed far enough in advance that the Claims Administrator has time to review the Claim before the care or treatment is provided.
- (d) *Failure to Follow Proper Procedures in Filing a Claim.* If you fail to follow the proper procedures in filing a Pre-Service Claim, the Claims Administrator will notify you as quickly as possible, but not later than 5 days after the failure took place.
- (e) *Deadline for Deciding a Claim.* The Claims Administrator will ordinarily decide a Pre-Service Claim within 15 days after it was received. The Claims Administrator may extend this 15 day period for up to an additional 15 days if the extension is necessary due to matters beyond the control of the Plan. You will be notified if the 15 day period is extended.
- (f) *Failure to Submit Necessary Information.* If you do not submit information that is necessary to process a Pre-Service Claim, the Claims Administrator will notify you of the failure within 15 days after your Claim is received and will identify the specific information that is necessary to process the Claim. You will have 45 days to provide the additional information. If the additional information is not provided within this time period, the Claim will be denied. If the additional information is provided, the Claims Administrator will decide the Claim within the number of days remaining in the original 15 day period (as extended).

- (g) *Notification Regarding Adverse Benefit Determination.* If a Pre-Service Claim is denied, the Claims Administrator will notify you in writing. The notice will explain why the Claim was denied and will provide information about your right to appeal the denial of the Claim.
- (h) *Appealing a Denial.* An appeal of a claims denial must be filed with the Claims Administrator within 180 days after your receipt of a notice of adverse benefit determination. The appeal will be decided by an individual or individuals appointed by the Claims Administrator who were not involved in the original decision to deny the claim. An appeal will be decided within 30 days after the Claims Administrator's receipt of your request for an appeal. You will be notified in writing of the decision that was reached on appeal. If your appeal was denied, the notice will explain why and will provide additional information about your rights.

### **Urgent Care Claims**

- (a) *Definition.* A claim is an "Urgent Care Claim" if a failure to treat the claim as urgent could have one of the following consequences: (1) In the judgment of a prudent layperson with average knowledge of health and medicine, would seriously jeopardize the life or health of the person for whom the claim is being submitted or the ability of that person to regain maximum function; or (2) In the opinion of a Physician with knowledge about the person's medical condition, would subject the person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- (b) *Filing an Urgent Care Claim.* An Urgent Care Claim may be filed with the Claims Administrator in writing. If circumstances make this impractical, an Urgent Care Claim may also be submitted electronically, over the telephone, or in some other way that ensures that the Claim is received by the Claims Administrator on a timely basis.
- (c) *Information That Must Be Provided When Filing an Urgent Care Claim.* An Urgent Care Claim must include the following information: (1) The medical care or treatment for which approval is being sought; (2) the name of the person, organization or entity to which the expense was or is to be paid; (3) the name of the claimant and the relationship of the claimant to the employee; (4) an explanation of why the medical care or treatment should be considered to be "urgent"; (5) the amount recovered or expected to be recovered under any other insurance arrangement or plan; (6) a statement that the portion of the expense for which reimbursement is being sought from this Plan has not been reimbursed and has not been reimbursed under any other plan; and (7) any other information relating to the medical care or treatment that the claimant considers relevant and which the claimant wishes the Claims Administrator to consider in reviewing the claim.
- (d) *Deadline for Filing a Claim.* An Urgent Care Claim must be filed with the Claims Administrator as quickly as possible after the claimant, or the claimant's authorized representative, becomes aware of the existence of the claim.
- (e) *Failure to Follow Proper Procedures in Filing a Claim.* If you (or your representative) fail to follow the proper procedures in filing a Pre-Service Claim, the Claims Administrator will notify you (or your representative) as quickly as possible, but not later than 24 hours after the failure took place.
- (f) *Deadline for Deciding an Urgent Care Claim.* The Claims Administrator will ordinarily decide an Urgent Care Claim within 72 hours after it was received.

- (g) *Failure to Submit Necessary Information.* If you do not submit information that is necessary to process an Urgent Care Claim, the Claims Administrator will notify you of the failure within 24 hours after your claim is received and will identify the specific information that is necessary to process the claim. You will have 48 hours to provide the additional information. If the additional information is not provided within this time period, the claim will be denied.
- (h) *Notification Regarding Adverse Benefit Determination.* The Claims Administrator will notify you if an Urgent Care Claim is denied. If the notification is provided orally, it will be followed within three days by a written notification. The written notification will explain why the claim was denied and will provide information about your right to appeal the denial of the claim.
- (i) *Appealing a Denial.* An appeal of a claims denial must be filed with the Claims Administrator within 180 days after your receipt of a notice of adverse benefit determination. The appeals procedure will be the same as for a Pre-Service Claim except that your request for an appeal may be submitted orally and all necessary information may be transmitted by telephone, fax, or similar methods. An appeal will be decided within 72 hours after the Claims Administrator's receipt of your request for an appeal. You will be notified in writing of the decision that was reached on appeal. If your appeal was denied, the notice will explain why and will provide additional information about your rights.

### **Concurrent Care Decisions**

- (a) *Definition.* A "Concurrent Care Decision" is a decision by the Claims Administrator to reduce or terminate a course of treatment that was previously approved, either before the expiration of the time period that was previously approved or before the number of treatments previously approved have been provided.
- (b) *Treatment as an Adverse Benefit Determination.* A Concurrent Care Decision will be treated as an adverse benefits determination. The Claims Administrator will notify the claimant of the decision. If the treatment is considered to be urgent, the notification will be given in accordance with the requirements applicable to Urgent Care Claims. Otherwise the notification will be given in accordance with the requirements applicable to Pre-Service Claims. Any such notification will be given sufficiently in advance of the reduction or termination to allow the claimant to appeal and to obtain a determination on review of the decision before it takes effect.

### **Extension of a Course of Treatment That Was Previously Approved**

The following rules apply if you request the extension of a course of treatment beyond the period of time or the number of treatments previously approved:

- (a) If the course of treatment involves urgent care, the request will be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator will notify you of the benefit determination within 24 hours after the receipt of your request.
- (b) Notification of the benefit determination will be provided in accordance with the provisions applicable to Urgent Care Claims, Pre-Service Care Claims, or Post-Service Care Claims, as may be applicable.

- (c) You will have the right to appeal an adverse benefit determination in accordance with the provisions applicable to Urgent Care Claims, Pre-Service Care Claims, or Post-Service Care Claims, as may be applicable.

These rules apply only if pre-authorization is required under the Plan.

### **Provisions Applicable to All Claims**

*Litigation of Claims Disputes.* Before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust the administrative remedies summarized in this SPD. This means, for example, that, if a claim is denied, you must appeal the denial following the procedures provided by the Plan. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under this Plan.

### **(14) Miscellaneous**

*Family and Medical Leave Act.* If you take an unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain your benefits under a Group Health Plan on the same terms and conditions as though you were still an active Employee.

If you choose to continue your coverage while you on an FMLA leave, the Employer will continue to pay its share (if any) of the premiums. You will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

- (a) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave (or with pre-tax dollars to the extent you receive compensation from the Employer during your leave).
- (b) You may pay your share of the premium pursuant to such other arrangement as may be agreed upon between you and the Plan Administrator.

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA.

### **(15) Notice of Hospital Rights for Newborns and Mothers**

HIPAA requires this Summary Plan Description to include the following explanation of your rights under the Health Insurance Portability and Accountability Act of 1996. Please note that this statement is made to you by the Federal government. Therefore, the Employer and the Plan Administrator are not responsible for the accuracy or completeness of the explanation, and some of the provisions may not apply to the Plan.

“Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).”

**(16) Notice of Rights under the Women’s Health and Cancer Rights Act of 1998**

The Employer is required by federal law to provide the following notice:

“If a group medical plan provides medical and surgical benefits for mastectomies, that plan must also provide coverage for the following, if they are agreed upon by a participant or beneficiary who is receiving benefits in connection with a mastectomy and that person’s attending physician:

- (a) Reconstruction of the breast on which the mastectomy has been performed;
- (b) Reconstruction of the other breast to produce a symmetrical appearance; and
- (c) Prostheses and physical complications of mastectomies, including lymphedemas.

This coverage must be the same as for any other benefit under the plan and is subject to the plan’s annual deductibles and co-payment requirements.”

**(17) Notice of Opportunity to Enroll Adult Children to Age 26**

Effective March 1, 2011, under the Patient Protection and Affordable Care Act of 2010, your children generally can be covered under the Employee Group Medical Plan until they attain age 26, regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them. Thus, children whose coverage under the Medical Plan ended, who were denied coverage, or who were not eligible for coverage, because the availability of dependent coverage of children under the Plan ended before attainment of age 26 may be eligible for coverage under the Plan beginning March 1, 2011.

Coverage is not available to children who have attained age 26 or who will attain age 26 on or before March 1, 2011. Coverage is also not available to an adult child who is eligible to enroll in another employer-provided group health plan (not including a plan of the child’s other parent’s employer. In order for your child to be covered under the Medical Plan, you must also be enrolled for coverage.

To request coverage for a child who has not attained age 26 as of March 1, 2011, proper enrollment materials must be completed and returned within thirty (30) days from the date this notice is *initially* provided to you (whether provided through this SPD or otherwise) to the Plan Administrator at the address provided at the beginning of this SPD. Any questions regarding this right may also be directed to the Plan Administrator.

**(18) No Lifetime Limit under the Medical Plan**

Effective March 1, 2011, the lifetime limit on the dollar value of benefits under the Medical Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Medical Plan are eligible to enroll in the Medical Plan. Individuals have 30 days from the date that this notice is *initially* provided to them, whether in this SPD or otherwise, to request enrollment. For more information, contact the Plan Administrator at the address provided at the beginning of this SPD.

**(19) Grandfathered Status Notice for the Medical Plan**

The Medical Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (“PPACA”). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections under PPACA that apply to other plans. For example, PPACA requires that preventive health services be provided by *non-grandfathered* plans without any cost sharing. Grandfathered health plans, however, do not have to provide preventive health services without any cost sharing. Grandfathered plans do have to comply with certain other consumer protections under PPACA, such as the following:

- the elimination of lifetime limits on essential health care benefits; and
- the prohibition on pre-existing condition exclusions (generally effective for plan years beginning on or after January 1, 2014, but effective for plan years beginning on or after September 23, 2010 for enrolled individuals under the age of 19).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the address provided at the beginning of this SPD. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

**(20) Right of Employer to Amend or Terminate**

The Employer may at any time amend or terminate this Plan and/or any of the Component Benefit Plans by a written instrument signed by the City Manager of the Employer, as provided for in each of the respective plan documents. Any amendment to any plan will be added to the Plan in writing and communicated to Participants.

\* \* \* \* \*

## APPENDIX A COBRA NOTICE PROCEDURES

As an individual covered by the Plan, your right to begin COBRA coverage or to extend or maintain current COBRA coverage is affected by the events listed in the first column of the table below. If you wish to qualify for COBRA continuation coverage, you must provide the Plan with notice of the occurrence of any one of these events in accordance with the procedures outlined in this table. Any required forms may be obtained from the Plan Administrator. Once completed, the various kinds of notices described below must be mailed or hand-delivered to the following address:

Penny Soukup  
City of Abilene  
P.O. Box 519  
Abilene, Kansas 67410

**Notice must be in writing. Oral notice, including notice by telephone is not acceptable. Electronic (including e-mailed or faxed) notices are also not acceptable. If mailed, notice must be postmarked no later than the deadline date. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline date.**

If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

The following terms have been abbreviated:           QE = Qualifying Event      QB = Qualified Beneficiary      SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES <sup>1</sup>	WHO MAY PROVIDE NOTICE
<p><b>DIVORCE OR LEGAL SEPARATION<sup>2</sup></b></p>	<p>Notice must be provided 60 days after the date on which covered spouse would lose coverage under the terms of the Plan as a result of the divorce or legal separation.</p>	<p>Your notice must contain the following:</p> <ul style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) Name/address of all QBs who lost coverage due to the QE;</li> <li>(4) The QE;</li> <li>(5) A copy of the divorce or legal separation decree;</li> <li>(6) Date of the QE; and</li> <li>(7) Signature, name and contact information of individual sending the notice.</li> </ul>	<p>If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:<sup>3</sup></p> <ul style="list-style-type: none"> <li>(1) Notice is mailed/hand-delivered to the address specified at the beginning of this Appendix;</li> <li>(2) Notice deadline is met;</li> <li>(3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and</li> <li>(4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the QE, and the date on which it occurred.</li> </ul>	<ul style="list-style-type: none"> <li>(1) Covered Employee;</li> <li>(2) Formerly Covered Employee;</li> <li>(3) A QB with respect to the QE; or</li> <li>(4) Representative acting on behalf of the covered (or formerly covered) employee or the QB.</li> </ul> <p>A notice provided by any of the above listed individuals will satisfy any responsibility to provide notice on behalf of all QBs who lost coverage due to the QE described in the notice.</p>

<sup>1</sup> In addition to the conditions listed in this column, for each qualifying event, the notice must also be supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from Employer for more information.

<sup>2</sup> *Anticipation of Divorce or Legal Separation.* If your coverage is reduced or eliminated and a divorce or legal separation later occurs, you may be able to receive COBRA coverage if you can show that your coverage was reduced or eliminated in anticipation of the divorce or legal separation. You must notify the Employer of this within 60 days of the divorce or legal separation in accordance with these procedures. You must also provide evidence satisfactory to the Employer that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

<sup>3</sup> If any one of the conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event

QB = Qualified Beneficiary

SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES <sup>1</sup>	WHO MAY PROVIDE NOTICE
<b>LOSS OF DEPENDENT STATUS UNDER THE PLAN</b>	Notice must be provided 60 days after the date on which the covered dependent child would lose coverage under the terms of the Plan due to the loss of dependent status.	<p>Your notice must contain the following:</p> <ul style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) Name/address of all QBs who lost coverage due to QE;</li> <li>(4) Statement of the QE;</li> <li>(5) Date of the QE;</li> <li>(6) If requested, documentation satisfactory to Employer of the date of the QE (e.g., a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution);<sup>4</sup> and</li> <li>(7) Signature, name and contact information of individual sending the notice.</li> </ul>	Same as above.	Same as above.
<b>DISABILITY</b>	<p>Notice must be provided 60 days after the latest of (1) the date of the SSA's disability determination; and (2) the date on which the QB would lose coverage under the terms of the Plan as a result of the termination of employment or reduction in hours.</p> <p>Your notice must also be provided within 18 months after the QEs of termination of employment and reduction of hours.</p>	<p>Your notice must contain the following:</p> <ul style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered under the Plan;</li> <li>(3) The initial QE that started COBRA coverage (i.e., termination of employment or reduction in hours);</li> <li>(4) Name/address of all QBs who lost coverage due to the initial QE and who are receiving COBRA coverage at the time of the notice;</li> <li>(5) Name/address of disabled QB;</li> <li>(6) Date of the QE;</li> <li>(7) Date SSA made its determination of disability;</li> <li>(8) Statement as to whether or not SSA has subsequently determined that QB is no longer disabled; and</li> <li>(9) Signature, name and contact information of individual sending the notice.</li> </ul> <p>Notice must include a copy of SSA's determination of disability.</p>	<p>If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:<sup>5</sup></p> <ul style="list-style-type: none"> <li>(1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix;</li> <li>(2) Notice deadline is met;</li> <li>(3) From the written notice provided, Employer can tell that the notice relates to the Plan and the QB's disability; and</li> <li>(4) From the written notice provided, Employer is able to identify the covered employee, the QB(s), the QE, and the date on which the covered employee's termination of employment or reduction in hours occurred.</li> </ul>	<p>Same as above.</p> <p>A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all QBs who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.</p>

<sup>4</sup> This will allow the Employer to determine that you gave timely notice of the QE and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the child ceased to be a dependent on the date specified in your notice of QE, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started.

<sup>5</sup> If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event

QB = Qualified Beneficiary

SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES <sup>1</sup>	WHO MAY PROVIDE NOTICE
<p><b>SECOND QUALIFYING EVENT</b></p> <p>–</p> <p><b>DIVORCE OR LEGAL SEPARATION</b></p>	<p>Notice must be provided 60 days after the date on which covered spouse would lose coverage under the terms of the Plan as a result of the divorce or legal separation if it had occurred while the QB was still actively covered under the Plan.</p>	<p>Your notice must contain the following:</p> <ul style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours);</li> <li>(4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice;</li> <li>(5) The second QE (i.e., divorce or legal separation);</li> <li>(6) Date of the second QE;</li> <li>(7) A copy of the decree of divorce or legal separation; and</li> <li>(8) Signature, name and contact information of individual sending the notice.</li> </ul>	<p>If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:<sup>6</sup></p> <ul style="list-style-type: none"> <li>(1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix;</li> <li>(2) Notice deadline is met;</li> <li>(3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and</li> <li>(4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.</li> </ul>	<ul style="list-style-type: none"> <li>(1) Covered Employee</li> <li>(2) Formerly Covered Employee</li> <li>(3) A QB who lost coverage due to the covered employee's termination or reduction of hours and who is still receiving COBRA coverage</li> <li>(4) Representative acting on behalf of the covered (or formerly covered) employee or the QB</li> </ul> <p>A notice provided by any of the above listed individuals will satisfy any responsibility to provide notice on behalf of all QBs who lost coverage due to the QE described in the notice.</p>
<p><b>SECOND QUALIFYING EVENT</b></p> <p>–</p> <p><b>LOSS OF DEPENDENT STATUS</b></p>	<p>Notice must be provided 60 days after the date on which covered dependent child would lose coverage under the terms of the Plan as a result of the second QE if the event had occurred while the QB was still actively covered under the Plan.</p>	<p>Your notice must contain the following:</p> <ul style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours);</li> <li>(4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice;</li> <li>(5) The second QE;</li> <li>(6) Date of the second QE;</li> <li>(7) If requested, documentation that is satisfactory to Employer (e.g., a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution) of the date of the QE;<sup>7</sup> and</li> <li>(8) Signature, name and contact information of individual sending the notice.</li> </ul>	<p>If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:<sup>8</sup></p> <ul style="list-style-type: none"> <li>(1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix;</li> <li>(2) Notice deadline is met;</li> <li>(3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and</li> <li>(4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.</li> </ul>	<p>Same as divorce (or legal separation) when it is a <i>second</i> QE.</p>

<sup>6</sup> If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

<sup>7</sup> This will allow the Employer to determine that you gave timely notice of the second QE and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the child ceased to be a dependent on the date specified in your notice, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage *would* have ended without an extension due to loss of dependent status.

<sup>8</sup> If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event

QB = Qualified Beneficiary

SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES <sup>1</sup>	WHO MAY PROVIDE NOTICE
<p><b>SECOND QUALIFYING EVENT</b></p> <p>—</p> <p><b>DEATH OF EMPLOYEE OR FORMERLY COVERED EMPLOYEE</b></p>	<p>Notice must be provided 60 days after the date on which covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the death of the covered employee or formerly covered employee if the death had occurred while the QB was still actively covered under the Plan.</p>	<p>Your notice must contain the following:</p> <ol style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) The initial QE that started your COBRA coverage (i.e., termination of employment or reduction of hours);</li> <li>(4) Name/address of all QBs who lost coverage due to above stated QE and who are receiving COBRA at the time of the notice;</li> <li>(5) The second QE;</li> <li>(6) Date of the second QE;</li> <li>(7) If requested, documentation of the date of the death that is satisfactory to Employer (e.g., a death certificate or published obituary);<sup>9</sup> and</li> <li>(8) Signature, name and contact information of individual sending the notice.</li> </ol>	<p>If you provide a notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely if all of the following conditions are met:<sup>10</sup></p> <ol style="list-style-type: none"> <li>(1) Notice is mailed/hand-delivered to address specified at the beginning of this Appendix;</li> <li>(2) Notice deadline is met;</li> <li>(3) From the written notice provided, the Employer can tell that the notice relates to the Plan; and</li> <li>(4) From the written notice provided, the Employer is able to identify the covered employee and QB(s), the first QE, the date on which the first QE occurred, the second QE, and the date on which the second QE occurred.</li> </ol>	<p>Same as divorce (or legal separation) when it is a <i>second</i> QE.</p>
<p><b>OTHER COVERAGE</b></p>	<p>Notice that a QB has become covered after electing COBRA under other group health plan, coverage must be provided 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the QB.</p>	<p>Your notice must contain the following:</p> <ol style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) Name/address of all QBs, specifying the one who obtained other coverage;</li> <li>(4) The QE that started your COBRA coverage;</li> <li>(5) Date of the QE;</li> <li>(6) The date the other coverage became effective;*</li> <li>(7) Evidence of the effective date of the other coverage (e.g., copy of insurance card or application for coverage); and</li> <li>(8) Signature, name and contact information of individual sending the notice.</li> </ol> <p>* If there were any preexisting condition exclusions applicable to the QB, include the date that these were exhausted or satisfied.</p>	<p>If a QB first becomes covered by other group health plan coverage after electing COBRA, that QB's COBRA coverage will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.</p>	<p>Same as divorce (or legal separation) when it is an initial QE.</p>

<sup>9</sup> This will allow the Employer to determine that you gave timely notice of the second QE and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from Employer that the death was the date specified in your notice of QE, the COBRA coverage of all QBs receiving an extension of COBRA as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death.

<sup>10</sup> If any one of the above conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

QE = Qualifying Event

QB = Qualified Beneficiary

SSA = Social Security Administration

NOTICE OF:	DEADLINE FOR PROVIDING NOTICE	REQUIRED INFORMATION IN THE NOTICE	INCOMPLETE NOTICES <sup>1</sup>	WHO MAY PROVIDE NOTICE
<b>MEDICARE ENTITLEMENT</b>	Notice that a QB has become entitled, after electing COBRA, to Medicare Part A, Part B or both, must be provided 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).	Your notice must contain the following: <ol style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) Name/address of all QBs, specifying the one who became entitled to Medicare;</li> <li>(4) The QE that started your COBRA coverage;</li> <li>(5) Date of that QE and the date that Medicare entitlement occurred;</li> <li>(6) A copy of the Medicare card showing the date of Medicare entitlement; and</li> <li>(7) Signature, name and contact information of individual sending the notice.</li> </ol>	If a QB first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that QB's COBRA coverage will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.
<b>CESSATION OF DISABILITY</b>	Notice that a disabled QB whose disability resulted in an extended COBRA coverage period is no longer disabled (as determined by the SSA) must be provided 30 days after the other coverage becomes effective or, if later, 30 days after the date of the SSA's determination.	Your notice must contain the following: <ol style="list-style-type: none"> <li>(1) Name of the Plan;</li> <li>(2) Name/address of employee or former employee who is/was covered;</li> <li>(3) Name/address of all QBs, specifying who was the disabled QB;</li> <li>(4) State the QE that started your COBRA coverage;</li> <li>(5) Date of the QE;</li> <li>(6) Date of the SSA's determination that QB is no longer disabled;</li> <li>(7) A copy of SSA determination; and</li> <li>(8) Signature, name and contact information of individual sending the notice.</li> </ol>	If a disabled QB is determined by SSA to be no longer disabled, COBRA coverage for all QBs whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described in the COBRA Continuation Coverage section of the SPD.	Same as divorce (or legal separation) when it is an initial QE.

**CITY OF ABILENE**  
**EMPLOYEE GROUP MEDICAL PLAN**

**CITY OF ABILENE  
EMPLOYEE GROUP MEDICAL PLAN**

The City of Abilene, Kansas (“Employer”) establishes this Group Medical Plan (“Medical Plan”) for the benefit of its Eligible Employees. This Medical Plan is available through the City of Abilene Cafeteria Plan (“Cafeteria Plan”). Any term used in the Cafeteria Plan has the same meaning in this Medical Plan, unless inconsistent with the provisions of this Medical Plan.

**ARTICLE I  
INTRODUCTION**

Section 1.01 Name of Plan. The name of this Plan is the City of Abilene Employee Group Medical Plan.

Section 1.02 Purpose of Plan. The purpose of this Plan is to provide eligible Employees with medical benefits.

Section 1.03 Qualified Plan Status. The Employer intends this Plan to qualify as a health plan within the meaning of Section 105(e) of the Code and that the benefits payable under this Plan be eligible for exclusion from gross income under Section 105(b) of the Code.

Section 1.04 Plan Operation. This Plan shall continue without interruption and may be reviewed and amended from time to time.

Section 1.05 [Reserved].

Section 1.06 Character of Benefits Provided. This Medical Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular medical service may not be eligible for reimbursement under this Medical Plan does not mean that a Participant or other person who is covered under this Medical Plan should not receive that service.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE II ELIGIBILITY AND PARTICIPATION

Section 2.01 Eligibility to Participate. Each Eligible Employee of the Employer is eligible to participate in this Medical Plan on the first day of the first month coincident with or next following completion of one day of active employment with the Employer.

Section 2.02 Special Eligibility Rule for Employees Changing from Part-Time to Full-Time Employment. Each Employee who is not an Eligible Employee, but who has completed one day of active employment with the Employer, becomes eligible to participate in this Medical Plan on the first day of the month coincident with or next following the date on which he or she becomes an Eligible Employee.

Section 2.03 Election to Participate. If an Eligible Employee wishes to participate in this Medical Plan, the Employee must complete the benefit election form provided by the Plan Administrator and make an election under the Cafeteria Plan to pay the applicable premium under this Medical Plan. An Employee becomes a Participant in this Medical Plan on the date specified on the Employee's benefit election form, provided the form has been properly completed and returned to the Plan Administrator, or the date the employee becomes eligible to participate in this Medical Plan, whichever is later.

Section 2.04 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) the last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) the date on which the Participant's election to participate expires;
- (c) the end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) the last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) the date on which this Medical Plan terminates.

Notwithstanding anything in this section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Medical Plan if and to the extent such individual elects continuation of benefits under the rules in Section 2.06.

Section 2.05 Reinstatement of Former Participant. A former Participant may participate in this Medical Plan again upon satisfaction of the eligibility requirements in Section 2.01 or, if applicable, Section 2.02. However, a former Participant who returns to active employment with the Employer after an unpaid leave of absence may become a Participant in this Medical Plan on the first day of the first month coincident with or next following such return.

Section 2.06 Continuation of Coverage under COBRA. If a "qualified beneficiary" loses (or would lose) coverage under this Plan as a result of a "qualifying event," the Plan Administrator will give that

qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Plan is subject to the following:

- (a) *Qualified Beneficiary.* For purposes of this section, a "qualified beneficiary" means the Participant, the Participant's spouse, and the Participant's dependents, but only if such persons were covered under this Plan on the day before the "qualifying event." The term "qualified beneficiary" shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.
- (b) *Qualifying Event.* For purposes of this section, a "qualifying event" means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:
  - (1) Termination of the Participant's employment (other than for "gross misconduct") or a reduction in the number of hours the Participant normally works.
  - (2) Death of the Participant.
  - (3) Divorce or legal separation of the Participant and the Participant's covered spouse.
  - (4) The Participant's entitlement to Medicare.
  - (5) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.
- (c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the plan administrator may establish.
- (d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.
- (e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:
  - (1) *Termination of Employment or Reduction in Hours.* Eighteen (18) months if coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours.
  - (2) *Disability Extension.* Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of COBRA coverage and the qualified beneficiary

notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.

- (3) *Second Qualifying Event.* Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.
- (4) *Any Other Qualifying Event.* Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this subsection (e).
- (f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if a qualified beneficiary becomes covered under another group health plan, if a required premium is not paid within the applicable deadline (including any applicable grace period), or if the Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees.
- (g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.
- (h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.
- (i) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the Internal Revenue Service and the Department of Health & Human Services.
- (j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering "controlled group" rules and special rules for part-time employees), this Section will apply as described above.

Section 2.07 [Reserved]

Section 2.08 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant's right to continue coverage is subject to the following:

- (a) *Payment of Premium*. The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence of less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, the Participant must pay the entire cost of coverage plus an additional 2%.
- (b) *Failure to Apply for Reemployment*. Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).
- (c) *Reasonable Procedures*. The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this section.
- (d) *Construction and Application*. This section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the Department of Labor.

[The remainder of this page is intentionally left blank.]

### **ARTICLE III MEDICAL BENEFITS**

Section 3.01 Medical Benefits. Benefits under this Medical Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract ("Group Contract") between Preferred Health Systems ("PHS") and the Employer (Group Contract #781101). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by PHS. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Medical Plan shall be determined from the Group Contract. The Participant shall bear fully any and all risk of PHS's insolvency.

Section 3.02 Election to Participate. If an Eligible Employee wishes to participate in this Medical Plan, the Employee must complete the benefit election form provided by the Plan Administrator and if necessary, elect, in accordance with the terms of the Cafeteria Plan, to reduce the Employee's Compensation in the amount of the applicable premium under Section 3.03.

Section 3.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Group Contract. Under that agreement, PHS may change the premiums from time to time. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV  
ADMINISTRATION OF THE PLAN**

Section 4.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this Medical Plan. The Plan Administrator has full discretionary authority to administer this Medical Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret this Medical Plan, and to decide all questions concerning this Medical Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this Medical Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this Medical Plan.

Section 4.02 Claims Administration. PHS will act as Claims Administrator with respect to any claim for benefits under this Medical Plan. PHS is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V**  
**[RESERVED]**

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VI  
ADMINISTRATION OF THE MEDICAL PLAN**

Section 6.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this Medical Plan. The Plan Administrator has full discretionary authority to administer this Medical Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret this Medical Plan, and to decide all questions concerning this Medical Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this Medical Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this Medical Plan.

Section 6.02 Claims Administration. PHS will act as Claims Administrator with respect to any claim for benefits under this Medical Plan. PHS is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VII  
[RESERVED]**

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VIII**  
**TERMINATION AND AMENDMENT OF THE PLAN**

Section 8.01 Termination and Amendment. The Employer may amend or terminate this Medical Plan at any time by written instrument signed by the City Manager of the Employer.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IX  
MISCELLANEOUS**

Section 9.01 Nonassignability. The right of any Participant to receive any benefits under this Medical Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 9.02 State Law. The laws of the State of Kansas will determine all questions arising with respect to the provisions of this Medical Plan except to the extent superseded by Federal law.

Section 9.03 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 9.04 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Medical Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 9.05 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions thereof, and this Plan shall be construed and enforced as if such provisions had not been included.

Section 9.06 Contract of Employment. Nothing contained herein shall be construed to constitute a contract of employment between the Employer and any Employee. Nothing contained herein shall be deemed to give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time without regard to the effect such discharge might have on the Employee as a participant under this Plan.

*[The remainder of this page intentionally left blank]*

IN WITNESS WHEREOF, the Employer adopts this Medical Plan effective the 1<sup>st</sup> day of March, 2010.



City of Abilene

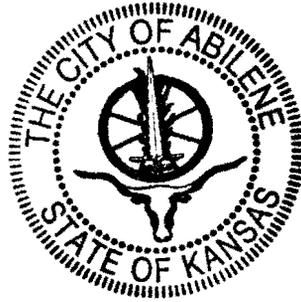
By: *Penny L. Soukup, CMC*  
Penny L. Soukup, CMC  
City Clerk/ Human Resource Manager

**CERTIFICATION BY THE EMPLOYER TO  
CITY OF ABILENE EMPLOYEE GROUP MEDICAL PLAN**

I hereby certify on behalf of City of Abilene (the "Plan Sponsor") that the City of Abilene Employee Group Medical Plan (the "Plan") has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii), effective as of March 1, 2010. I further certify on behalf of the Plan Sponsor that the Plan Sponsor agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of Protected Health Information by the Plan to the Plan Sponsor. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

**CITY OF ABILENE**

By: Perry L. Soukup Date: 8-10-10



**CITY OF ABILENE**  
**EMPLOYEE GROUP VISION PLAN**

**CITY OF ABILENE  
EMPLOYEE GROUP VISION PLAN**

City of Abilene (“Employer”) adopts this Vision Plan for the benefit of its Eligible Employees. This Vision Plan is available through the City of Abilene Cafeteria Plan (“Cafeteria Plan”). Any term used in the Cafeteria Plan has the same meaning in this Vision Plan, unless inconsistent with the provisions of this Vision Plan.

**ARTICLE I  
INTRODUCTION**

Section 1.01    Name of Plan. The name of this Plan is the City of Abilene Employee Group Vision Plan.

Section 1.02    Purpose of Plan. The purpose of this Plan is to provide eligible Employees with vision benefits.

Section 1.03    Health Plan Status. The Employer intends this Plan to qualify as a health plan within the meaning of Section 105(e) of the Code and that the benefits payable under this Plan be eligible for exclusion from gross income under Section 105(b) of the Code.

Section 1.04    Plan Operation. This Plan shall continue without interruption and may be reviewed and amended from time to time.

Section 1.05    [Reserved.]

Section 1.06    Character of Benefits Provided. This Vision Plan does not provide vision treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Group Contract. The fact that a particular vision service may not be eligible for reimbursement under this Vision Plan does not mean that a Participant or other person who is covered under this Vision Plan should not receive that service.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE II DEFINITIONS**

Section 2.01 “Claims Administrator” means the Plan Administrator, unless the Employer retains another person to serve as the claims fiduciary for this Vision Plan with the authority to grant or deny claims for benefits.

Section 2.02 “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.03 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.04 “Effective Date” means the original date on which this Vision Plan took effect, which date is March 1, 2009; provided, however, that if this Vision Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.05 “Eligible Employee” means an Employee, other than a Temporary Employee, actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding thirty (30) hours. Such status will be deemed to continue during any paid leave of absence approved by the Employer. An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less.

Section 2.06 “Employee” means an individual employed by the Employer, including any individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or who is treated as a partner under Section 1372 of the Code. The term “Employee” excludes those persons covered by a collective bargaining agreement and those persons classified by the Employer on its payroll records as "leased employees" as that term is used in Section 414(n) of the Code.

Section 2.07 “Employer” means City of Abilene, Kansas.

Section 2.08 “Participant” means an Employee who participates in this Vision Plan in accordance with Article III.

Section 2.09 “Plan Administrator” means the Employer. The Employer may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this Plan in a manner consistent with the terms of this Plan.

Section 2.10 “Plan Year” means the fiscal year of this Vision Plan, the twelve (12) consecutive month period ending every February 28.

Section 2.11 “Temporary Employee” means an Employee who is employed for a limited time period not exceeding 120 consecutive days.

Section 2.12 “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

*[The remainder of this page is intentionally left blank.]*

### **ARTICLE III ELIGIBILITY AND PARTICIPATION**

Section 3.01 Eligibility to Participate. Each Eligible Employee of the Employer is eligible to participate in this Vision Plan on the first day of the month following or coincident with one day of active employment.

- (a) *Special Rule for Eligible Employees Employed on the Effective Date.* All Eligible Employees who are employed by the Employer on the Effective Date will be eligible to participate in this Vision Plan on the Effective Date, without regard to whether such Eligible Employees have completed one day of active employment.

Section 3.02 [Reserved.]

Section 3.03 Election to Participate. If an Eligible Employee wishes to participate in this Vision Plan, the Employee must complete the benefit election form provided by the Plan Administrator and make an election under the Cafeteria Plan to pay the applicable premium under this Vision Plan. An Employee becomes a Participant in this Vision Plan on the date specified on the Employee's benefit election form, provided the form has been properly completed and returned to the Plan Administrator, or the date the employee becomes eligible to participate in this Vision Plan, whichever is later.

Section 3.04 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The date on which the Participant's election to participate expires;
- (c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) The date on which this Vision Plan terminates.

Notwithstanding anything in this section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Vision Plan if and to the extent such individual elects continuation of benefits under the rules in Section 3.06.

Section 3.05 Reinstatement of Former Participant. A former Participant may participate in this Vision Plan again upon satisfaction of the eligibility requirements in Section 3.01 or, if applicable, Section 3.02. However, a former Participant who returns to active employment with the Employer after an unpaid leave of absence may become a Participant in this Vision Plan on the first day of the first month coincident with or next following such return.

Section 3.06 Continuation of Coverage under COBRA. If a “qualified beneficiary” loses (or would lose) coverage under this Plan as a result of a “qualifying event,” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary’s right to continue coverage under this Plan is subject to the following:

- (a) *Qualified Beneficiary.* For purposes of this section, a “qualified beneficiary” means the Participant, the Participant’s spouse, and the Participant’s dependents, but only if such persons were covered under this Plan on the day before the “qualifying event.” The term “qualified beneficiary” shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.
- (b) *Qualifying Event.* For purposes of this section, a “qualifying event” means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:
  - (1) Termination of the Participant’s employment (other than for “gross misconduct”) or a reduction in the number of hours the Participant normally works.
  - (2) Death of the Participant.
  - (3) Divorce or legal separation of the Participant and the Participant’s covered spouse.
  - (4) The Participant’s entitlement to Medicare.
  - (5) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.
- (c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the plan administrator may establish.
- (d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the plan administrator may establish.
- (e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:
  - (1) *Termination of Employment or Reduction in Hours.* Eighteen (18) months if coverage is lost as a result of termination of the Participant’s employment or a reduction in the Participant’s hours.

- (2) *Disability Extension.* Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.
- (3) *Second Qualifying Event.* Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.
- (4) *Any Other Qualifying Event.* Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this subsection (e).
- (f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if a qualified beneficiary becomes covered under another group health plan, if a required premium is not paid within the applicable deadline (including any applicable grace period), or if the Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees.
- (g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.
- (h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.
- (i) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the Internal Revenue Service and the Department of Labor.
- (j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering "controlled group" rules and special rules for part-time employees), this Section will apply as described above.

Section 3.07 [Reserved].

Section 3.08 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant's right to continue coverage is subject to the following:

- (a) *Payment of Premium*. The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence of less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, the Participant must pay the entire cost of coverage plus an additional 2%.
- (b) *Failure to Apply for Reemployment*. Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).
- (c) *Reasonable Procedures*. The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this section.
- (d) *Construction and Application*. This section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the Department of Labor.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE IV VISION BENEFITS**

Section 4.01 Vision Benefits. Benefits under this Vision Plan are identical to those described in, and shall be paid pursuant to the terms of, the group contract (“Group Contract”) between Vision Service Plan Insurance Company (“VSP”) or Vision Care Direct and the Employer (Group Contract #30013104-VSP or #3568-Vision Care Direct). The provisions of that contract, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by VSP or Vision Care Direct, as applicable. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under this Vision Plan shall be determined from the Group Contract. The Participant shall bear fully any and all risk of VSP’s or Vision Care Direct’s insolvency.

Section 4.02 Election to Participate. If an Eligible Employee wishes to participate in this Vision Plan, the Employee must complete the benefit election form provided by the Plan Administrator and if necessary, elect, in accordance with the terms of the Cafeteria Plan, to reduce the Employee's Compensation in the amount of the applicable premium under Section 4.03.

Section 4.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the Group Contract. Under that agreement, VSP or Vision Care Direct, as applicable, may change the premiums from time to time. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V  
RESERVED**

**ARTICLE VI  
ADMINISTRATION OF THE VISION PLAN**

Section 6.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this Vision Plan. The Plan Administrator has full discretionary authority to administer this Vision Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret this Vision Plan, and to decide all questions concerning this Vision Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this Vision Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this Vision Plan.

Section 6.02 Claims Administration. VSP or Vision Care Direct, as applicable, will act as Claims Administrator with respect to any claim for benefits under this Vision Plan. VSP or Vision Care Direct, as applicable, is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VII  
TERMINATION AND AMENDMENT OF THE VISION PLAN**

Section 7.01 Termination and Amendment. The Employer may amend or terminate this Vision Plan at any time by written instrument duly adopted by the Employer.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE VIII MISCELLANEOUS**

Section 8.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 8.02 Employment Not Guaranteed. Nothing contained in this Vision Plan or in any other plan which is a part of the Vision Plan, or any modification or amendment to this Vision Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Vision Plan.

Section 8.03 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Vision Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Vision Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 8.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Vision Plan.

Section 8.05 Limitation on Liability. A Vision Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Vision Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 8.06 Named Fiduciary. The named fiduciary of this Vision Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Vision Plan.

Section 8.07 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;
- (b) The amounts the Participant has elected to defer into a plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this Vision Plan or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's vision coverage prior to deducting any other amounts.

Section 8.08 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Vision Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 8.09 Nonassignability. The right of any Participant to receive any benefits under this Vision Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 8.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Vision Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Vision Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Vision Plan on a retroactive basis.

Section 8.11 Return of Premium. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section 8.12 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Vision Plan, and then only to the extent that the benefits payable under the Component Benefit Plans are payable solely from the assets of the Employer.

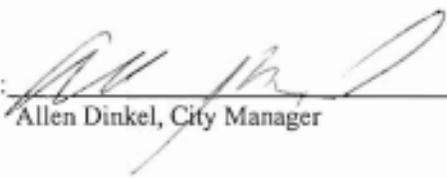
Section 8.13 Separate Liability. No fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this Vision Plan, by the Code, or by any regulations or rulings issued under the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this Vision Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 8.14 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Vision Plan except to the extent superseded by Federal law.

*[The remainder of this page is intentionally left blank.]*

IN WITNESS WHEREOF, the Employer adopts this Vision Plan effective the 28<sup>th</sup> day of February, 2009.

**CITY OF ABILENE**

By:   
Allen Dinkel, City Manager

**CITY OF ABILENE**  
**PRESCRIPTION DRUG PLAN**

**CITY OF ABILENE  
PRESCRIPTION DRUG PLAN**

The City of Abilene, Kansas (“Employer”) establishes this Prescription Drug Plan (“Prescription Drug Plan”) for the benefit of its Eligible Employees. This Prescription Drug Plan is available through the City of Abilene Cafeteria Plan (“Cafeteria Plan”). Any term used in the Cafeteria Plan has the same meaning in this Prescription Drug Plan, unless inconsistent with the provisions of this Prescription Drug Plan.

**ARTICLE I  
INTRODUCTION**

Section 1.01 Name of Plan. The name of this Plan is the City of Abilene Prescription Drug Plan.

Section 1.02 Purpose of Plan. The purpose of this Plan is to provide eligible Employees with prescription drug benefits.

Section 1.03 Qualified Plan Status. The Employer intends this Plan to qualify as a health plan within the meaning of Section 105(e) of the Code and that the benefits payable under this Plan be eligible for exclusion from gross income under Section 105(b) of the Code.

Section 1.04 Plan Operation. This Plan shall continue without interruption and may be reviewed and amended from time to time.

Section 1.05 Funding Policy and Method. The prescription drug benefits under this Prescription Drug Plan are funded by the Employer. The cost of providing these prescription drug benefits is paid for by Employer and Employee contributions. The Employer, in its sole discretion, may purchase a group insurance policy to fund some or all of the benefits under this Prescription Drug Plan.

Section 1.06 Character of Benefits Provided. This Prescription Drug Plan does not provide prescription advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the Benefit Description. The fact that a particular prescription drug service may not be eligible for reimbursement under this Prescription Drug Plan does not mean that a Participant or other person who is covered under this Prescription Drug Plan should not receive that service.

Section 1.07 Subrogation/Reimbursement Rights of the Prescription Drug Plan.

- (a) Prescription Drug Plan’s Right to Subrogation. The Prescription Drug Plan shall be subrogated to all rights that a Participant, Covered Dependent, or his/her assignee has against any person, firm, corporation, insurer (including, but not limited to, worker’s compensation or any other occupational disease act or law, uninsured motorist coverage, and business/homeowners medical insurance coverage or payments) or other entity with respect to *any and all benefits* previously paid by the Prescription Drug Plan, or on behalf of the Prescription Drug Plan, to such individual for any injuries, expenses, or loss which may be caused by the negligence or wrongful act of a third party.

- (b) Plan's Right to Reimbursement. A Participant, Covered Dependent, or assignee agrees to include the amounts of any and all benefits paid by the Prescription Drug Plan (or any amount considered to be for future medical expenses) in any claim such individual brings against any person, firm, corporation, insurer, or other entity. Upon any recovery made by a Participant, Covered Dependent, or assignee from any source of compensation, whether by judgment, settlement, compromise, or otherwise, the Prescription Drug Plan shall have first lien upon such recovery and be entitled to immediate reimbursement to the extent of any and all benefits paid by the Prescription Drug Plan.

Section 1.08 Amount of Recovery. The Prescription Drug Plan has the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the Prescription Drug Plan. The amount due shall not be reduced due to attorney's fees and/or costs incurred in pursuing a claim or reimbursement. In addition, these rights take priority over the Participant's, Covered Individual's, or assignee's right to be made whole.

Section 1.09 Condition of Payment. By accepting benefits from the Prescription Drug Plan, a Participant, Covered Dependent, or his/her assignee agrees to the following:

- (a) The Prescription Drug Plan may require a Participant, Covered Dependent, assignee, or someone legally qualified and authorized to act for such person, to agree to the provisions in this Prescription Drug Plan, Sections 1.08 and 1.09 in writing, and execute any and all other instruments reasonably necessary for the Prescription Drug Plan to assert its rights under these Sections;
- (b) Any amounts recovered by such individual or by the Prescription Drug Plan by judgment, settlement, or otherwise will be applied first to reimburse the Prescription Drug Plan;
- (c) The Prescription Drug Plan shall be subrogated to all claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the Prescription Drug Plan; and
- (d) At the Prescription Drug Plan's request, a Participant, Covered Dependent, or assignee must take any action, give information, and/or execute instruments required by the Prescription Drug Plan, in its discretion, in order to aid the Prescription Drug Plan in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual fails to comply with such requests, the Prescription Drug Plan may withhold benefits, services, payments, or credits due under the Plan.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE II ELIGIBILITY AND PARTICIPATION**

Section 2.01 Eligibility to Participate. Each Eligible Employee of the Employer is eligible to participate in this Prescription Drug Plan on the first day of the first month coincident with or next following completion of one day of active employment with the Employer.

Section 2.02 Special Eligibility Rule for Employees Changing from Part-Time to Full-Time Employment. Each Employee who is not an Eligible Employee, but who has completed one day of active employment with the Employer, becomes eligible to participate in this Prescription Drug Plan on the first day of the month coincident with or next following the date on which he or she becomes an Eligible Employee.

Section 2.03 Election to Participate. If an Eligible Employee wishes to participate in this Prescription Drug Plan, the Employee must complete the benefit election form provided by the Plan Administrator and make an election under the Cafeteria Plan to pay the applicable premium under this Prescription Drug Plan. An Employee becomes a Participant in this Prescription Drug Plan on the date specified on the Employee's benefit election form, provided the form has been properly completed and returned to the Plan Administrator, or the date the employee becomes eligible to participate in this Prescription Drug Plan, whichever is later.

Section 2.04 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) the last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) the date on which the Participant's election to participate expires;
- (c) the end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;
- (d) the last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (e) the date on which this Prescription Drug Plan terminates.

Notwithstanding anything in this section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Prescription Drug Plan if and to the extent such individual elects continuation of benefits under the rules in Section 2.06.

Section 2.05 Reinstatement of Former Participant. A former Participant may participate in this Prescription Drug Plan again upon satisfaction of the eligibility requirements in Section 2.01 or, if applicable, Section 2.02. However, a former Participant who returns to active employment with the Employer after an unpaid leave of absence may become a Participant in this Prescription Drug Plan on the first day of the first month coincident with or next following such return.

Section 2.06 Continuation of Coverage under COBRA. If a “qualified beneficiary” loses (or would lose) coverage under this Plan as a result of a “qualifying event,” the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary’s right to continue coverage under this Plan is subject to the following:

- (a) *Qualified Beneficiary.* For purposes of this section, a “qualified beneficiary” means the Participant, the Participant’s spouse, and the Participant’s dependents, but only if such persons were covered under this Plan on the day before the “qualifying event.” The term “qualified beneficiary” shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.
- (b) *Qualifying Event.* For purposes of this section, a “qualifying event” means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:
  - (1) Termination of the Participant’s employment (other than for “gross misconduct”) or a reduction in the number of hours the Participant normally works.
  - (2) Death of the Participant.
  - (3) Divorce or legal separation of the Participant and the Participant’s covered spouse.
  - (4) The Participant’s entitlement to Medicare.
  - (5) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.
- (c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the plan administrator may establish.
- (d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.
- (e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:
  - (1) *Termination of Employment or Reduction in Hours.* Eighteen (18) months if coverage is lost as a result of termination of the Participant’s employment or a reduction in the Participant’s hours.

- (2) *Disability Extension.* Twenty-nine (29) months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first sixty (60) days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.
- (3) *Second Qualifying Event.* Thirty-six (36) months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.
- (4) *Any Other Qualifying Event.* Thirty-six (36) months for any qualifying event for which a shorter maximum coverage period is not set forth in this subsection (e).
- (f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if a qualified beneficiary becomes covered under another group health plan, if a required premium is not paid within the applicable deadline (including any applicable grace period), or if the Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees.
- (g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.
- (h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.
- (i) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the Internal Revenue Service and the Department of Health & Human Services.
- (j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as

determined under COBRA (considering “controlled group” rules and special rules for part-time employees), this Section will apply as described above.

Section 2.07 [Reserved]

Section 2.08 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. The Participant’s right to continue coverage is subject to the following:

- (a) *Payment of Premium*. The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence of less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, the Participant must pay the entire cost of coverage plus an additional 2%.
- (b) *Failure to Apply for Reemployment*. Following completion of the Participant’s military service, the Participant’s right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).
- (c) *Reasonable Procedures*. The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this section.
- (d) *Construction and Application*. This section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the Department of Labor.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE III  
PRESCRIPTION DRUG BENEFITS**

Section 3.01 Prescription Drug Benefits. Benefits under this Prescription Drug Plan are identical to those described in, and shall be paid pursuant to the terms of, the Serve You Benefit Description (“Benefit Description”) prepared for the Employer (Group #3496) by Serve You. The provisions of the Benefit Description, as it may be amended from time to time, are incorporated herein by reference and the rights and conditions with respect to the benefits payable under this Prescription Drug Plan shall be determined from the Benefit Description; provided, however, that should there be any contradictions between the Benefit Description and this document, this document will control.

Section 3.02 Election to Participate. If an Eligible Employee wishes to participate in this Prescription Drug Plan, the Employee must complete the benefit election form provided by the Plan Administrator and if necessary, elect, in accordance with the terms of the Cafeteria Plan, to reduce the Employee's Compensation in the amount of the applicable premium under Section 3.03.

Section 3.03 Cost of Coverage. The Participant's monthly premiums are determined by the Employer. The Employer may change the premiums from time to time. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV  
ADMINISTRATION OF THE PLAN**

Section 4.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this Prescription Drug Plan. The Plan Administrator has full discretionary authority to administer this Prescription Drug Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret this Prescription Drug Plan, and to decide all questions concerning this Prescription Drug Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this Prescription Drug Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this Prescription Drug Plan.

Section 4.02 Claims Administration. Serve You will act as Claims Administrator and are hereby delegated full discretionary authority to make all determinations regarding the administration and payment of benefit claims, in accordance with the terms of the Group Contracts. All decisions of the Claims Administrator shall be final and binding.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V  
HIPAA MEDICAL PRIVACY**

**PART I  
PREAMBLE**

Section 5.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Except as otherwise provided, this Article shall be effective as of April 14, 2004 (the “Effective Date”).

Section 5.02 Application of Article. This Article shall apply to City of Abilene Employee Group Prescription Drug Plan (hereafter referred to as the “Group Health Plan”) and shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

**PART II  
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER**

Section 5.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information to the Employer.

Section 5.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

- (a) “*Breach* means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a “breach:”
  - (1) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;
  - (2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and
  - (3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

- (b) *“De-identified Health Information”* means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.
- (c) *“Electronic Media”* means:
- (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
  - (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (d) *“Electronic Protected Health Information”* (*“e-PHI”*) is PHI that is transmitted or maintained in electronic media.
- (e) *“Individually Identifiable Health Information”* means information for which each of the following conditions is met:
- (1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;
  - (2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual;
  - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (f) *“Plan Administration Functions”* means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.
- (g) *“Protected Health Information”* means Individually Identifiable Health Information except that Protected Health Information does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

- (h) “*Security Incident*” (as defined in 45 C.F.R. 164,304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (i) “*Security Rule*” shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.
- (j) “*Summary Health Information*” means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided prescription drug coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five digit ZIP code.
- (k) “*Unsecured PHI*” means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 5.05 Enrollment / Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the prescription drug coverage provided under the Group Health Plan.

Section 5.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose Protected Health Information to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;
- (b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any appeals that are filed with respect to claims that are denied in whole or in part;
- (c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;
- (d) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits;
- (e) Detecting fraud or abuse;
- (f) Determining whether charges for services are appropriate or justified;
- (g) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance;
- (h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;

- (i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;
- (j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;
- (k) Reporting corporate finances with respect to current and projected healthcare costs;
- (l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of Protected Health Information pursuant to this Section 5.06 is subject to the provisions of Section 5.07.

Section 5.07 Conditions for Disclosure for Plan Administration Functions. With respect to any Protected Health Information that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 5.06, the Employer agrees to do the following:

- (a) Not use or further disclose Protected Health Information other than as permitted or required by the Group Health Plan document or as required by law;
- (b) Ensure that any agents or subcontractors to whom the Employer provides Protected Health Information received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information;
- (c) Not to use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;
- (d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and the Department of Health and Human Services (“HHS”) may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;

- (e) Effective February 17, 2010, restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;
- (f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his or her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;
- (g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;
- (h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;
- (i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;
- (j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;
- (l) Provide a certification to the Group Health Plan as required by Section 7.08; and
- (m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:
  - (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;
  - (2) Ensures that any agents (including subcontractors) to whom it provides such e-PHI agrees to implement reasonable and appropriate security measures to protect the information; and
  - (3) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section 5.08 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations. The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 5.07 and in Part III.

### **PART III ADMINISTRATIVE SAFEGUARDS**

Section 5.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to Protected Health Information from the Group Health Plan except as set forth in this Part III. This Part III does not apply to information that is not considered to be Protected Health Information, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 5.10 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to Protected Health Information to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to participants:

City Manager  
City Clerk / Privacy Officer

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing Protected Health Information due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy rules and shall comply fully with the Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 5.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to Protected Health Information to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 5.12 Consequences of Unauthorized Use of PHI. If it is determined that an Employee has obtained, used, or disclosed Protected Health Information in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VI**  
**ADMINISTRATION OF THE PRESCRIPTION DRUG PLAN**

Section 6.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this Prescription Drug Plan. The Plan Administrator has full discretionary authority to administer this Prescription Drug Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret this Prescription Drug Plan, and to decide all questions concerning this Prescription Drug Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this Prescription Drug Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this Prescription Drug Plan.

Section 6.02 Claims Administration. Serve You will act as Claims Administrator with respect to any claim for benefits under this Prescription Drug Plan. Serve You is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE VII CLAIMS PROCEDURES**

Section 7.01 Where to File Claims. Any claim for benefits which arises under a group health plan of the Plan shall be filed with the Claims Administrator.

Section 7.02 Persons Who May File Claims. Claims may be filed by the claimant or by the claimant's duly authorized representative.

- (a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.
- (b) Notwithstanding the foregoing rule, a health care professional with knowledge of the claimant's medical condition shall be permitted to act as the authorized representative of the claimant with respect to Urgent Care Claims (as defined in Section 7.51).

Sections 7.03 - 7.09 [Reserved.]

### **PART I - POST-SERVICE CLAIMS**

Section 7.10 Application of Part I. Sections 7.10 through 7.29 apply to Post-Service Claims, as defined below.

Section 7.11 Definition of Post-Service Claim. A Post-Service Claim is a claim that is submitted after the underlying medical care or treatment has already been provided.

Section 7.12 Previously Approved Pre-Service Claims and Urgent Care Claims. A Pre-Service Claim (as defined in Section 7.31) that has been approved in accordance with the provisions applicable to Pre-Service Claims or an Urgent Care Claim (as described in Section 7.51) that has been approved in accordance with the procedures applicable to Urgent Care Claims will be treated as a Post-Service Claim once the underlying medical care or treatment has been provided and will be subject to the provisions of the Plan that apply to Post-Service Claims. In such an event, however, the Claims Administrator will not deny coverage for any medical care or treatment that had previously been approved under the procedures applicable to Pre-Service Claims or Urgent Care Claims.

Section 7.13 How to File a Claim. Claims must be filed using the form or forms prescribed by the Claims Administrator and shall include the following information:

- (a) The amount, date and nature of each expense;
- (b) The name of the person, organization or entity to which the expense was or is to be paid;
- (c) The name of the claimant for whom the expense was incurred and, if such person is not the Employee requesting the benefit, the relationship of such claimant to the Employee;
- (d) The amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense; and

- (e) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other plan coverage.

Section 7.14 Time Period for Filing Claims. Claims must be received by the Claims Administrator no later than twelve (12) months after the date on which the claim was incurred. A claim that is not filed within this time period will be denied.

Section 7.15 Deadline for Deciding Claims. The Claims Administrator shall decide a Post-Service Claim that has been submitted in accordance with the provisions of this Article not later than 30 days following the receipt of the claim. The Claims Administrator may extend this 30-day period for up to 15 additional days if the extension is necessary due to matters beyond the control of the Plan *and* the claimant is notified of the extension prior to the expiration of the original 30-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the claimant fails to submit information that is necessary to decide a claim.

Section 7.16 Failure to Submit Necessary Information. If the claimant or the claimant's authorized representative fails to submit information that is necessary to process a Post-Service Claim, the Claims Administrator shall notify the claimant or the claimant's authorized representative of such failure within 30 days following the receipt of the claim and shall identify the specific information that is necessary to complete the claim.

- (a) Upon receipt of such notification, the claimant or the claimant's authorized representative shall have 45 days to provide the requested information to the Claims Administrator.
- (b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the claim, as set forth in Section 7.15, shall be suspended.
- (c) Following receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the claim within the number of days that were remaining in the original 30-day period (as extended) as of the date the additional information was requested.
- (d) If the requested information is not received by the Claims Administrator within 45 days after the claimant or the claimant's authorized representative received the Claims Administrator's request for such information, the Claims Administrator shall deny the claim.

Section 7.17 Notification Regarding Adverse Benefit Determination. The Claims Administrator shall notify the claimant in writing if a Post-Service Claim is denied. The notice provided to the claimant shall be written in a manner calculated to be understood by the claimant and shall set forth the following:

- (a) The specific reason(s) for denial of the claim;
- (b) A reference to the specific Plan provisions upon which the denial is based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim, along with an explanation why such material or information is necessary;

- (d) A description of the Plan's claim review procedures and the time limits applicable to such procedures;
- (e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- (f) If the denial of the claim is based on the lack of “medical necessity” or an exclusion for “experimental treatment” or other, similar exclusions or limits, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided free of charge upon request.

Section 7.18 Deadline for Filing an Appeal. The claimant shall have 180 days following receipt of a notice of an adverse benefit determination to file an appeal. Any appeal shall be filed with the Claims Administrator.

Section 7.19 Procedures for an Appeal. In any appeal filed pursuant to Section 7.18, the following procedures shall be observed:

- (a) The Claims Administrator shall designate an appropriate individual or individuals to consider the appeal. The individual(s) considering the appeal shall not be the same individual(s) who originally decided the claim nor shall they be subordinates of the individual(s) who originally decided the claim;
- (b) In considering the appeal, no deference shall be given to the initial adverse benefit determination;
- (c) If initial adverse benefit determination was based on a medical judgment, including a judgment as to whether treatment was “medically necessary” or “experimental,” the individual(s) considering the appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial adverse benefit determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial adverse benefit determination; and
- (d) In connection with the appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial adverse benefit determination, regardless of whether such advice was relied upon in making the initial adverse benefit determination.

Section 7.20 Deadline for Deciding an Appeal. An appeal that has been filed in accordance with Section 7.18 shall be decided within 60 days following the Claims Administrator’s receipt of the Claimant’s request for the appeal.

Section 7.21 [Reserved]

Section 7.22 Notification Regarding Decision on Appeal. The Claims Administrator shall notify the claimant of the decision made on appeal. In the case of an adverse benefit determination, the notice shall set forth the following:

- (a) The specific reason(s) for the adverse determination;
- (b) A reference to the specific plan provisions upon which the determination is based;
- (c) 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 information relevant to the claimant's claim;
- (d) A statement describing any voluntary appeal rights (if the group health plan is amended at a later date to provide such rights);
- (e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- (f) If the denial of the claim is based on the lack of "medical necessity" or an exclusion for "experimental treatment" or other similar exclusions or limits, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided free of charge upon request; and
- (g) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Sections 7.23-7.29 [Reserved.]

## **PART II - PRE-SERVICE CLAIMS**

Section 7.30 Application of Part II. Sections 7.30 through 7.49 apply to Pre-Service Claims, as defined below.

Section 7.31 Definition of Pre-Service Claim. A Pre-Service Claim is a claim for which each of the following conditions is satisfied:

- (a) The benefit payable by the Plan depends, in whole or in part, upon the approval of the underlying medical care or treatment by the Plan's Utilization Review Organization; and
- (b) The claim is not an Urgent Care Claim (as defined in Section 7.51).

Section 7.32 How to File a Pre-Service Claim. A Pre-Service Claim must be filed using the form or forms prescribed by the Claims Administrator and shall include the following information:

- (a) The amount, date and nature of each expense;
- (b) The name of the person, organization or entity to which the expense was or is to be paid;
- (c) The name of the claimant for whom the approval is being sought and, if such person is not the Employee requesting the benefit, the relationship of such claimant to the Employee;
- (d) An explanation of why the medical care or treatment in question should be approved;
- (e) The amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense; and
- (f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under any other Plan coverage.

Section 7.33 Time Period for Filing a Pre-Service Claim. A Pre-Service Claim must be received by the Claims Administrator sufficiently in advance of the proposed treatment date that the Claims Administrator is able to process the claim.

Section 7.34 Failure to Follow Proper Procedures in Filing a Pre-Service Claim. If the claimant or the claimant's authorized representative fails to follow the proper procedures in filing a Pre-Service Claim, the Claims Administrator shall notify the claimant or the claimant's authorized representative as quickly as possible. In no event will the notification be made more than five days after the time the failure took place.

Section 7.35 Deadline for Deciding a Pre-Service Claim. Following the submission of a Pre-Service Claim that has been filed in accordance with the provisions of this Part, the Claims Administrator shall decide the Pre-Service Claim not later than 15 days following the receipt of the claim. The Claims Administrator may extend this 15-day period for up to 15 additional days if the extension is necessary due to matters beyond the control of the Plan *and* the claimant is notified of the extension prior to the expiration of the original 15-day period. A situation that is beyond the control of the Plan includes, but is not limited to, a situation in which the claimant fails to submit information that is necessary to decide a claim.

Section 7.36 Failure to Submit Necessary Information. If the claimant or the claimant's authorized representative fails to submit information that is necessary to process a Pre-Service Claim, the Claims Administrator shall notify the claimant or the claimant's authorized representative of such failure and shall identify the specific information that is necessary to complete the claim.

- (a) Upon receipt of such notification, the claimant or the claimant's authorized representative shall have 45 days to provide the requested information to the Claims Administrator.
- (b) During the period between the date the additional information is requested and the date it is received by the Claims Administrator, the deadline for deciding the claim, as set forth in Section 7.35, shall be suspended.

- (c) Following receipt of the additional information that was requested by the Claims Administrator, the Claims Administrator shall decide the claim within the number of days that were remaining in the original 15-day period (as extended) as of the date the additional information was requested.
- (d) If the requested information is not received by the Claims Administrator within 45 days after the claimant or the claimant's authorized representative received the Claims Administrator's request for such information, the Claims Administrator shall deny the claim.

Section 7.37 Notification Regarding Decision on a Pre-Service Claim. The Claims Administrator shall notify the claimant in writing of the decision that has been made on a Pre-Service Claim. If the claim is denied, the notice provided to the claimant shall be written in a manner calculated to be understood by the claimant and shall set forth the following:

- (a) The specific reason(s) for denial of the claim;
- (b) A reference to the specific Plan provisions upon which the denial is based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim, along with an explanation why such material or information is necessary;
- (d) A description of the Plan's claim review procedures and the time limits applicable to such procedures;
- (e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- (f) If the denial of the claim is based on the lack of "medical necessity" or an exclusion for "experimental treatment" or other, similar exclusions or limits, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided free of charge upon request.

Section 7.38 Deadline for Filing an Appeal. The claimant shall have 365 days following receipt of a notice of an adverse benefit determination to file an appeal. Any appeal shall be filed with the Claims Administrator.

Section 7.39 Procedures for an Appeal. In any appeal filed pursuant to Section 7.38, the following procedures shall be observed:

- (a) The Claims Administrator shall designate an appropriate individual or individuals to consider the appeal. The individual(s) considering the appeal shall not be the same individual(s) who originally decided the claim nor shall they be subordinates of the individual(s) who originally decided the claim;

- (b) In considering the appeal, no deference shall be given to the initial adverse benefit determination;
- (c) If initial adverse benefit determination was based on a medical judgment, including a judgment as to whether treatment was “medically necessary” or “experimental,” the individual(s) considering the appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any health care professional who is consulted for this purpose shall not have been involved with or consulted regarding the initial adverse benefit determination nor shall such a professional be a subordinate of any professional who was involved with or consulted regarding the initial adverse benefit determination; and
- (d) In connection with the appeal, the Claims Administrator must identify any medical or vocational experts whose advice was obtained on behalf of the plan in making the initial adverse benefit determination, regardless of whether such advice was relied upon in making the initial adverse benefit determination.

Section 7.40 Deadline for Deciding an Appeal. An appeal that has been filed in accordance with Section 7.38 shall be decided within 30 days following the Claims Administrator’s receipt of the claimant’s request for the appeal.

Section 7.41 [Reserved]

Section 7.42 Notification Regarding Decision on Appeal. The Claims Administrator shall notify the claimant of the decision made on appeal. If the decision is adverse, the Claims Administrator shall provide a written notice that sets forth the following:

- (a) The specific reason(s) for the adverse determination;
- (b) A reference to the specific plan provisions upon which the determination is based;
- (c) 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 information relevant to the claimant’s claim;
- (d) A statement describing voluntary appeal rights (if the group health plan is amended at a later date to provide such rights);
- (e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- (f) If the denial of the claim is based on the lack of “medical necessity” or an exclusion for “experimental treatment” or other, similar exclusions or limits, the notification shall either

contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided free of charge upon request; and

- (g) The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Sections 7.43 - 7.49 [Reserved.]

### **PART III - URGENT CARE CLAIMS**

Section 7.50 Application of Part III. Sections 7.50 through 7.69 apply to Urgent Care Claims, as defined below.

Section 7.51 Definition of Urgent Care Claim. An Urgent Care Claim is a claim for which a failure to treat the claim as urgent:

- (a) Could, in the judgment of a prudent layperson with average knowledge of health and medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- (b) Would, in the opinion of a physician with knowledge of the claimant’s medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Section 7.52 How to File an Urgent Care Claim. An Urgent Care Claim shall include the following information:

- (a) The medical care or treatment for which approval is being sought;
- (b) The name of the person, organization or entity to which the expense was or is to be paid;
- (c) The name of the claimant for whom the approval is being sought and, if such person is not the Employee requesting the benefit, the relationship of such claimant to the Employee;
- (d) An explanation of why the medical care or treatment in question should be considered to be urgent;
- (e) The amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense;
- (f) A statement that the expense (or portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under any other Plan coverage; and

- (g) Any other information relating to the medical care or treatment in question that the claimant considers relevant and which the claimant wishes the Claims Administrator to consider in reviewing the claim.

An Urgent Care Claim may be filed in writing. If the circumstances make the filing of a written Claim impractical, an Urgent Care Claim may also be submitted to the Claims Administrator electronically, over the telephone, or in some other way that is similarly expeditious and which ensures that the Urgent Care Claim is received by the Claims Administrator on a timely basis.

Section 7.53 Time Period for Filing an Urgent Care Claim. An Urgent Care Claim must be filed with the Claims Administrator as quickly as possible after the claimant or the claimant's authorized representative becomes aware of the existence of the claim.

Section 7.54 Failure to Follow Proper Procedures in Filing an Urgent Care Claim. If the claimant or the claimant's authorized representative fails to follow the proper procedure in filing an Urgent Care Claim, the Claims Administrator shall notify the claimant or the claimant's authorized representative as quickly as possible. In no event will the notification be made more than 24 hours after the time the failure took place.

Section 7.55 Failure to Submit Necessary Information. If the claimant or the claimant's authorized representative fails to submit information that is necessary to process the Urgent Care Claim, the Claims Administrator shall notify the claimant or the claimant's authorized representative of such failure, shall identify the specific information that is necessary to complete the claim, and shall state that the claimant or the claimant's authorized representative shall have a period of not less than 48 hours to provide the additional information that has been requested. Such notification shall be provided as quickly as possible after the claim has been received. In no event, will such notification be provided more than 24 hours after the claim has been received.

Section 7.56 Deadline for Deciding an Urgent Care Claim. Following the submission of an Urgent Care Claim that has been filed in accordance with the provisions of this Article, the Claims Administrator shall decide the Urgent Care Claim as quickly as possible. In no event will the decision on the claim be made more than 72 hours after the claim has been received.

Section 7.57 Notification Regarding Initial Benefit Determination for an Urgent Care Claim. The Claims Administrator shall notify the claimant of the Initial Benefit Determination on an Urgent Care Claim. For a claim that has been denied, the notice provided to the claimant shall be written in a manner calculated to be understood by the claimant and shall set forth the following:

- (a) The specific reason(s) for denial of the claim;
- (b) A reference to the specific Plan provisions upon which the denial is based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim, along with an explanation why such material or information is necessary;

- (d) A description of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the expedited review process applicable to Urgent Care Claims;
- (e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the notification shall either state the internal rule, guideline, protocol, or other criterion that was used, or, include a statement that such a criterion was used and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- (f) If the denial of the claim is based on the lack of “medical necessity” or an exclusion for “experimental treatment” or other, similar exclusions or limits, the notification shall either contain an explanation of the scientific or clinical judgment for such determination or a statement that such explanation will be provided free of charge upon request.

The notification required by this Section 7.57 as to the approval or denial of a claim may be provided orally if a written notification is provided within three days after the oral notification.

Section 7.58 Deadline for Filing an Appeal for an Urgent Care Claim. The claimant shall have 365 days following receipt of a notice of an adverse benefit determination to file an appeal. Any appeal shall be filed with the Claims Administrator.

Section 7.59 Procedure for an Appeal of an Urgent Care Claim. The procedure for an appeal of an Urgent Care Claim shall be the same as the procedure for the appeal of a Pre-Service Care Claim, as set forth in Section 7.39, except that the Claims Administrator must allow a request for an expedited appeal to be submitted orally or in writing by the claimant and all necessary information shall be transmitted between the Claims Administrator and the Claimant by telephone, facsimile, or any other similarly expeditious method.

Section 7.60 Notification Regarding Decision on Appeal of an Urgent Care Claim. The Claims Administrator shall notify the claimant of the decision made on appeal. The notification shall be in writing and the content of the notification shall be the same as that required for the notification of the decision made on appeal of a Pre-Service Claim, as set forth in Section 7.42. The Claims Administrator shall transmit the determination that has been made on appeal to the claimant by telephone, facsimile, or any other similarly expeditious method.

Sections 7.61 - 7.69 [Reserved.]

#### **PART IV - CONCURRENT CARE DECISIONS**

Section 7.70 Application of Part IV. Sections 7.70 through 7.79 apply to Concurrent Care Decisions, as defined below.

Section 7.71 Definition of Concurrent Care Decision. A Concurrent Care Decision is a decision to reduce or terminate a course of treatment previously approved before the expiration of the time period previously approved or before the Claimant had received the number of treatments previously approved. Because the Plan does not, as a general rule, require pre-approval for a course of treatment, it is anticipated that Concurrent Care decisions will arise only where a Claimant seeks to extend a non-emergency

hospitalization beyond the period originally approved or seeks to remain hospitalized beyond the period that is automatically approved for emergencies or following childbirth.

Section 7.72 Procedures Applicable to Concurrent Care Decisions. A Concurrent Care Decision shall be treated as an adverse benefit determination. The Claims Administrator shall notify the Claimant of the Concurrent Care Decision. If the treatment is considered to be urgent, the notification shall be given in accordance with the requirements applicable to Urgent Care Claims. Otherwise, the notification shall be given in accordance with the requirements applicable to Pre-Service Claims. Any such notification shall be given sufficiently in advance of the reduction or termination to allow the Claimant to appeal and to obtain a determination on review of that adverse benefit determination before it takes effect.

Section 7.73 Extension of a Course of Treatment. The following rules apply if a Claimant requests the extension of a course of treatment beyond the period of time or number of treatments previously approved:

- (a) If the course of treatment involves urgent care, the request shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Claimant of the benefit determination within 24 hours after receipt of the request;
- (b) Notification of the benefit determination shall be provided in accordance with the provisions applicable to Urgent Care Claims, Pre-Service Care Claims, or Post-Service Care Claims, as may be applicable; and
- (c) The Claimant shall have the right to appeal an adverse benefit determination in accordance with the provisions applicable to Urgent Care Claims, Pre-Service Care Claims, or Post-Service Care Claims, as may be applicable.

Sections 7.74 - 7.79 [Reserved.]

#### **PART V - PROVISIONS COMMON TO ALL CLAIMS**

Section 7.80 Duties of Claims Administrator. The Claims Administrator shall have the discretionary power and authority to perform the following duties:

- (a) Make determinations as to the eligibility of individuals to participate in this Plan and/or to be considered as a Dependent;
- (b) Make determinations relating to coverage under the Plan, including termination and continuation of a Participant's coverage;
- (c) Receive claims for benefits and render decisions respecting such claims under this Plan;
- (d) Compute the amounts payable for any Participant or other person in accordance with the provisions of this Plan, determine the manner and time of payment, and determine and authorize the person or persons to whom such payments will be paid;

- (e) Whenever it may be necessary, investigate and determine the eligibility for coverage of an applicant where the existence of any fact, status, or circumstance is a condition of coverage;
- (f) Make discretionary interpretations regarding the terms relating to administration of claims under this Plan, its interpretations to be final and conclusive on all persons claiming benefits under this Plan;
- (g) Make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of claims under this Plan;
- (h) Adopt such rules and procedures relating to the administration of claims as it deems necessary or desirable;
- (i) Be responsible for all claims administration reporting and disclosure requirements for this Plan under the law;
- (j) Receive from the Company, Employees, Participants and other persons such information as shall be necessary for the proper administration of claims under this Plan;
- (k) Furnish to the Company upon request, reports with respect to the administration of claims under this Plan;
- (l) Maintain all claims administration records of this Plan; and
- (m) Provide for and administer a mechanism for the appeal of denied claims in accordance with the provisions of this Plan.

Section 7.81 Litigation of Claim. Prior to initiating legal action concerning a claim in any court, state or Federal, against this Plan, any trust used in conjunction with this Plan, the Company, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the administrative remedies provided in this Article. Failure to exhaust the administrative remedies provided in this Article shall be a bar to any civil action concerning a Claim for benefits under this Plan.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VIII  
TERMINATION AND AMENDMENT OF THE PLAN**

Section 8.01 Termination and Amendment. The Employer may amend or terminate this Prescription Drug Plan at any time by written instrument signed by the City Manager of the Employer.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IX  
MISCELLANEOUS**

Section 9.01 Nonassignability. The right of any Participant to receive any benefits under this Prescription Drug Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 9.02 State Law. The laws of the State of Kansas will determine all questions arising with respect to the provisions of this Prescription Drug Plan except to the extent superseded by Federal law.

Section 9.03 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 9.04 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Prescription Drug Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 9.05 Severability. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions thereof, and this Plan shall be construed and enforced as if such provisions had not been included.

Section 9.06 Contract of Employment. Nothing contained herein shall be construed to constitute a contract of employment between the Employer and any Employee. Nothing contained herein shall be deemed to give any Employee the right to be retained in the employ of the Employer or to interfere with the right of the Employer to discharge any Employee at any time without regard to the effect such discharge might have on the Employee as a participant under this Plan.

*[The remainder of this page intentionally left blank]*

IN WITNESS WHEREOF, the Employer adopts this Prescription Drug Plan effective the 1<sup>st</sup> day of March, 2010.



City of Abilene

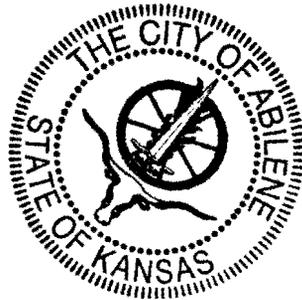
By: *Penny L. Soukup, CMC*  
Penny L. Soukup, CMC  
City Clerk/ Human Resource Manager

**CERTIFICATION BY THE EMPLOYER TO  
CITY OF ABILENE PRESCRIPTION DRUG PLAN**

I hereby certify on behalf of City of Abilene (the "Plan Sponsor") that the City of Abilene Prescription Drug Plan (the "Plan") has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii), effective as of March 1, 2010. I further certify on behalf of the Plan Sponsor that the Plan Sponsor agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of Protected Health Information by the Plan to the Plan Sponsor. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

**CITY OF ABILENE**

By: Penyol Soukup Date: 8-10-10



**CITY OF ABILENE**  
**HEALTH FLEXIBLE SPENDING ACCOUNT PLAN**

**CITY OF ABILENE  
HEALTH FLEXIBLE SPENDING ACCOUNT PLAN**

City of Abilene ("Employer") adopts this Health Flexible Spending Account Plan ("Health FSA") for the benefit of its Eligible Employees. This Health FSA is available through the City of Abilene Cafeteria Plan ("Cafeteria Plan"). Any term used in the Cafeteria Plan has the same meaning in this Health FSA, unless inconsistent with the provisions of this Health FSA.

The Employer has designed this Health FSA to enable Participants in this Health FSA to elect to receive reimbursements for their qualified unreimbursed medical expenses incurred during a Plan Year. The Employer intends this Health FSA to qualify under Section 105 of the Internal Revenue Code so the Employer's reimbursements under this Health FSA are excludable from the Participant's gross income.

**ARTICLE I  
ELIGIBILITY AND PARTICIPATION**

Section 1.01 Eligibility. An Employee is eligible to become a Participant in this Health FSA if the Employee is an Eligible Employee and the Employee has completed one (1) day of active employment with the Employer.

Section 1.02 Election to Participate. To become a Participant in this Health FSA, an Eligible Employee must make an election under the Cafeteria Plan to participate in this Health FSA. Such an election must be made pursuant to the terms and provisions of the Cafeteria Plan.

Section 1.03 Plan Entry Date. An election to participate in this Health FSA shall take effect as follows:

- (a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Cafeteria Plan, the election shall take effect as of the first day of the next plan year;
- (b) If the Eligible Employee's election was made within thirty (30) days after the Eligible Employee first became eligible to participate in this Health FSA, the election shall take effect as of the first day of the month following or coincident with the date that the completed election form is received by the Plan Administrator; or
- (c) If the Eligible Employee's election was made within thirty (30) days after an event that would allow an election change to be made under the terms of the Cafeteria Plan, the election shall take effect as of the first day of the month on or after the date that the completed election form is received by the Plan Administrator; provided, however, that this Section 1.03(c) shall apply if and only if the Eligible Employee had not previously been a Participant in this Health FSA at any time during the Plan Year.

Section 1.04 Election Changes. Once an Eligible Employee has become a Participant in this Health FSA, he/she may not make any election changes during the middle of a Plan Year. The preceding sentence shall not, however, apply to an election change which a Participant is entitled to make in connection with leave under the FMLA.

Section 1.05 FMLA Leave. A Participant who is taking or returning from FMLA leave shall have the following options with respect to his/her participation in this Health FSA:

- (a) *Taking FMLA Leave.* Upon commencement of FMLA leave, a Participant may continue his/her coverage under this Health FSA by continuing to pay the applicable premium during the period of the FMLA leave or by making such other arrangements as may be permitted under the provisions of the Cafeteria Plan. Alternatively, upon commencement of FMLA leave, a Participant may revoke his/her participation in this Health FSA, in which event the Participant will no longer be covered under this Health FSA as of the date that his/her FMLA leave commenced.
  
- (b) *Returning from FMLA Leave.* If a Participant's participation in this Health FSA was terminated when the Participant began his/her FMLA leave, the former Participant may, upon returning to work from an FMLA leave, elect to resume his/her participation in this Health FSA as of the date that he/she returns to work.
  - (i) Such a Participant may elect to resume coverage at the prior coverage level, in which event the Participant will be required to make up the premiums that would have been due during the period the Participant was on FMLA leave.
  
  - (ii) In lieu of making up the missed premiums, such a Participant may instead choose to resume coverage at a reduced level. In such an event, the Participant's coverage for the Plan Year shall be reduced on a pro rata basis by the portion of the Plan Year that the Participant was absent from work due to his/her FMLA leave.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE II MEDICAL REIMBURSEMENT

Section 2.01 Qualified Medical Expense. The term “Qualified Medical Expense” means an expense incurred by the Participant, or by the spouse or Dependent (as defined in Code § 152(a) without regard to subsections (b)(1), (b)(2) or (d)(1)(B) and to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than one-half their support for the calendar year from one or both parents and are in the custody of one or both parents for at least one-half of the calendar year)) of a Participant, for medical care as defined in Code § 213(d). The term includes, but is not limited to, amounts paid for hospital bills, doctor and dental bills or prescription medicine and drugs, but does not include reimbursement paid for other health coverage for other plans maintained by the Employer or reimbursement for over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription.

Section 2.02 Reimbursement. The Employer will reimburse the Participant in the Plan Year for Qualified Medical Expenses incurred by the Participant during the Plan Year subject to the other limitations of this Health FSA. However, the Employer will not make any reimbursement to a Participant if the Participant receives reimbursement for the expense through insurance or under any other means. The Employer will only reimburse for Qualified Medical Expenses incurred while the employee participates in the Health FSA. An expense is incurred when the Participant is provided with the medical care that gives rise to the Qualified Medical Expenses, and not when the Participant is formally billed or charged for, or pays for the medical care.

Section 2.03 Reimbursable Qualified Medical Expenses. The following expenses constitute Qualified Medical Expenses that may be reimbursed under this Health FSA:

- (a) Deductibles and copayment amounts the Participant pays under his or her medical and/or dental and/or vision care coverage; and
- (b) Medical and/or dental and/or vision care expenses in excess of usual, reasonable and customary rates; and
- (c) Any Code § 213(d) medical, dental, or vision care expenses not reimbursed by insurance; provided, however, over-the-counter drugs or medicine (other than insulin) that are not purchased pursuant to a prescription are not eligible for reimbursement as Qualified Medical Expenses.

The Plan Administrator has discretion to construe and apply what may be reimbursable under this Plan in accordance with such final or informal guidance as the IRS might provide.

Section 2.04 Maximum Amount of Reimbursement. The maximum amount of reimbursement for any Plan Year is the lesser of \$3,000, or the amount of the Participant's Health FSA. A Participant may not carry over an unused amount to a succeeding year. The Employer will reimburse the Participant throughout the coverage period for the total amount the Participant elects to reduce Compensation irrespective of whether the Participant has made sufficient salary reductions to his or her Health FSA.

Section 2.05 Withholding - Accounting. The Employer will establish and maintain a Health FSA for each Participant who has elected to receive the Health FSA benefit under this Health FSA. The Employer will credit to the Participant's Health FSA an amount of the Participant's Compensation which he or she elects to reduce. The amounts credited to the Participant's Health FSA are the property of the Employer until the

Employer actually makes reimbursement to the Participant. The Employer will debit a Participant's Health FSA for the amount of the reimbursement made for the Participant. A Participant's Health FSA will never exceed the dollar amount specified in Section 2.04 above of this Health FSA.

Section 2.06 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's Health FSA for any Plan Year to reimburse the Participant for Qualified Medical Expenses. If any balance remains in the Participant's Health FSA for any Plan Year after the Employer has made the reimbursements for the Plan Year, the Participant will forfeit the unused amount.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV**  
**TERMINATION OF HEALTH FLEXIBLE SPENDING ACCOUNT AND**  
**CONTINUATION OF COVERAGE**

Section 4.01 Termination of Participation.

- (a) *General Rule.* A Participant will cease participation in this Health FSA on the earlier of the following dates:
- (1) The date on which this Health FSA terminates; or
  - (2) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this Health FSA terminates on the above date, coverage or benefits under the Health FSA may continue if and to the extent provided by such benefit.

If a Participant ceases to be a Participant in this Health FSA for any reason, the Participant's election to receive reimbursements for Qualified Medical Expenses terminates on that date. The Participant may only receive reimbursement for Qualified Medical Expenses incurred within the same Plan Year and prior to the first day after the day the Participant terminates participation in this Health FSA. Notwithstanding anything in this section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Health FSA if and to the extent such an individual elects continuation of benefits under the rules in Section 4.03 below. If a Participant ceases participation under this Health FSA, the Participant must apply for reimbursement in accordance with Article-III through the end of the Plan Year for claims dated prior to the Participant's termination date.

Section 4.02 Continuation of Coverage under COBRA. If a "qualified beneficiary" loses (or would lose) coverage under this Plan as a result of a "qualifying event," the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Plan is subject to the following:

- (a) *Qualified Beneficiary.* For purposes of this section, a "qualified beneficiary" means the Participant, the Participant's spouse, and the Participant's dependents, but only if such persons were covered under this Plan on the day before the "qualifying event." The term "qualified beneficiary" shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.

COBRA coverage under the Health FSA will only be offered to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if he or she has been reimbursed for an amount that is less than his or her contributions through the time of the qualifying event.

- (b) *Qualifying Event.* For purposes of this section, a "qualifying event" means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:
- (1) Termination of the Participant's employment (other than for "gross misconduct") or a reduction in the number of hours the Participant normally works.
  - (2) Death of the Participant.

- (3) Divorce or legal separation of the Participant and the Participant's covered spouse.
  - (4) The Participant's entitlement to Medicare.
  - (5) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.
- (c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the plan administrator may establish. Each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate premium.
  - (d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional 2% charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional 50% charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the plan administrator may establish.
  - (e) *Maximum Coverage Period.* COBRA coverage will end on the *last day of the plan year* in which the qualifying event occurred, regardless of the qualifying event. Any unused amount will be forfeited at the end of the Plan Year.
  - (f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if a qualified beneficiary becomes covered under another group health plan, if a required premium is not paid within the applicable deadline (including any applicable grace period), or if the Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees.
  - (g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.
  - (h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.
  - (i) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the Internal Revenue Service and the Department of Health and Human Services.

- (j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the “small employer” exception to COBRA based on the number of employees that it employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering “controlled group” rules and special rules for part-time employees), this Section will apply as described above.

Section 4.03 Limits on Continuation Coverage. Reimbursements under Section 4.02 above shall be made for expenses incurred in any Plan Year only if the Participant applies for such reimbursement in accordance with Article III through the end of the Plan Year for claims dated prior to the Participant's termination date. In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements permitted under Section 4.02 above. No reimbursement under Section 4.02 above shall exceed the remaining balance, if any, in the Participant's health flexible spending account for the Plan Year in which the expenses were incurred.

Section 4.04 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to twenty-four (24) months. If, however, a Participant exercised his or her right to continue coverage under USERRA before December 10, 2004, the Participant's right to continue coverage is limited to a maximum period of eighteen (18) months if such coverage would otherwise be lost as a result of such military service. The Participant's right to continue coverage is subject to the following:

- (a) *Payment of Premium.* The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence of less than thirty-one (31) days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than thirty (30) days, the Participant must pay the entire cost of coverage plus an additional 2%.
- (b) *Failure to Apply for Reemployment.* Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).
- (c) *Reasonable Procedures.* The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this section.
- (d) *Construction and Application.* This section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the Department of Labor.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V**  
**HIPAA MEDICAL PRIVACY**

**PART I**  
**PREAMBLE**

Section 5.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Section 5.02 Application of Article. This Article shall apply to City of Abilene Health Flexible Spending Account Plan (hereafter referred to as the “Group Health Plan”) and shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

**PART II**  
**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER**

Section 5.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose Protected Health Information to the Employer.

Section 5.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

- (a) *“Breach”* means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a “breach:”
- (1) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;
  - (2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and
  - (3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

- (b) *“De-identified Health Information”* means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.
- (c) *“Individually Identifiable Health Information”* means information for which each of the following conditions is met:
  - (1) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;
  - (2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual;
  - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (d) *“Plan Administration Functions”* means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.
- (e) *“Protected Health Information”* means Individually Identifiable Health Information except that Protected Health Information does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.
- (f) *“Summary Health Information”* means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five digit ZIP code.
- (g) *“Unsecured PHI”* means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 5.05 Enrollment / Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 5.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose Protected Health Information to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

- (a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;
- (b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any appeals that are filed with respect to claims that are denied in whole or in part;
- (c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;
- (d) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of benefits;
- (e) Detecting fraud or abuse;
- (f) Determining whether charges for services are appropriate or justified;
- (g) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance;
- (h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;
- (i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;
- (j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;
- (k) Reporting corporate finances with respect to current and projected healthcare costs;
- (l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of Protected Health Information pursuant to this Section 5.06 is subject to the provisions of Section 5.07.

Section 5.07 Conditions for Disclosure for Plan Administration Functions. With respect to any Protected Health Information that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 5.06, the Employer agrees to do the following:

- (a) Not use or further disclose Protected Health Information other than as permitted or required by the Group Health Plan document or as required by law;
- (b) Ensure that any agents or subcontractors to whom the Employer provides Protected Health Information received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information;
- (c) Not to use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;
- (d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and the Department of Health and Human Services (“HHS”) may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;
- (e) Effective February 17, 2010, restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;
- (f) Make the Protected Health Information that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual’s right to access his or her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;
- (g) Make Protected Health Information available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;
- (h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual’s Protected Health Information in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;
- (i) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA’s medical privacy requirements;

- (j) If feasible, return or destroy all Protected Health Information received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III; and
- (l) Provide a certification to the Group Health Plan as required by Section 5.08.

Section 5.08 Certification by the Employer. In the absence of an authorization, the Group Health Plan may not disclose any Protected Health Information to the Employer unless and until the Group Health Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the Group Health Plan has been amended to incorporate the provisions required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations. The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 5.07 and in Part III.

### **PART III ADMINISTRATIVE SAFEGUARDS**

Section 5.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 5.10 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to participants:

City Manager  
City Clerk / Privacy Officer

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy rules and shall comply fully with the Plan's policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 5.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 5.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VI  
TERMINATION AND AMENDMENT OF THE HEALTH FSA**

The Employer may amend or terminate this Health FSA at any time by written instrument duly adopted by the Employer.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE VII MISCELLANEOUS

Section 7.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 7.02 Employment Not Guaranteed. Nothing contained in this Health FSA or in any other plan which is a part of the Health FSA, or any modification or amendment to this Health FSA, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Health FSA.

Section 7.03 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Health FSA is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this Health FSA, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 7.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Health FSA.

Section 7.05 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Health FSA unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 7.06 Named Fiduciary. The named fiduciary of this Health FSA shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Health FSA.

Section 7.07 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;
- (b) The amounts the Participant has elected to defer into a plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this Health FSA or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

Section 7.08 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Health FSA will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 7.09 Nonassignability. The right of any Participant to receive any benefits under this Health FSA is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 7.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Health FSA due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Health FSA on a prospective basis only.

Section 7.11 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Health FSA, and then only to the extent that the benefits payable under the Component Benefit Plans are payable solely from the assets of the Employer.

Section 7.12 Separate Liability. No fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this Health FSA, by the Code, or by any regulations or rulings issued under the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this Health FSA unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 7.13 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Health FSA except to the extent superseded by Federal law.

*[The remainder of this page intentionally left blank.]*

IN WITNESS WHEREOF, the Employer adopts this Health FSA effective the 1st day of April, 2004.

**CITY OF ABILENE**

By: \_\_\_\_\_  
Mark Arbuthnot, City Manager

**CERTIFICATION BY THE EMPLOYER TO  
CITY OF ABILENE HEALTH FLEXIBLE SPENDING ACCOUNT PLAN**

I hereby certify on behalf of City of Abilene (the "Plan Sponsor") that the City of Abilene Health Flexible Spending Account Plan (the "Plan") has been amended to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2)(ii), effective as of April 14, 2004. I further certify on behalf of the Plan Sponsor that the Plan Sponsor agrees to comply with the provisions of the Plan, as amended, governing the use and disclosure of Protected Health Information by the Plan to the Plan Sponsor. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

**CITY OF ABILENE**

By: \_\_\_\_\_

Date: \_\_\_\_\_

**CITY OF ABILENE**  
**DEPENDENT CARE ASSISTANCE PLAN**

**CITY OF ABILENE  
DEPENDENT CARE SPENDING ASSISTANCE PLAN**

City of Abilene ("Employer") adopts this Dependent Care Spending Account Plan ("DCAP") for the benefit of its Eligible Employees. This DCAP is a part of the City of Abilene Cafeteria Plan ("Cafeteria Plan"). Any term used in the Cafeteria Plan has the same meaning in this DCAP, unless inconsistent with the terms of this DCAP.

The Employer has designed this DCAP to enable Participants in this DCAP to elect to receive reimbursements for their Qualified Dependent Care Expenses during a Plan Year. The Employer intends this DCAP to qualify under Section 129 of the Internal Revenue Code so the Employer's reimbursements under this DCAP are excludable from the Participant's gross income.

**ARTICLE I  
ELIGIBILITY AND PARTICIPATION**

Section 1.01 Eligibility. An Employee is eligible to become a Participant in this DCAP if the Employee is an Eligible Employee and the Employee has completed one (1) day of active employment with the Employer.

Section 1.02 Election to Participate. To become a Participant in this DCAP, an Eligible Employee must make an election under the Cafeteria Plan to participate in this DCAP. Such an election must be made pursuant to the terms and provisions of the Cafeteria Plan.

Section 1.03 Plan Entry Date. An election to participate in this DCAP shall take effect as follows:

- (a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Cafeteria Plan, the election shall take effect as of the first day of the next plan year;
- (b) If the Eligible Employee's election was made within thirty (30) days after the Eligible Employee first became eligible to participate in this DCAP, the election shall take effect as of the first day of the month following or coincident with the date that the completed election form is received by the Claims Administrator; or
- (c) If the Eligible Employee's election was made within thirty (30) days after an event that would allow an election change to be made under the terms of the Cafeteria Plan, the election shall take effect as of the first day of the month on or coincident with the date that the completed election form is received by the Claims Administrator.

Section 1.04 Election Changes. A Participant in this DCAP may change his/her election during the middle of a Plan Year, either as to participation in this Plan or as to the dollar amount of the benefit elected, if and only if such an election change is permitted under the terms of the Cafeteria Plan.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE II**  
**DEPENDENT CARE REIMBURSEMENT**

Section 2.02 Qualified Dependent Care Expense. The term “Qualified Dependent Care Expense” means an amount paid by the Participant for care of a Dependent, including related household services, which enables the Participant to be gainfully employed.

- (a) *Dependent Care Expenses That Are Not “Qualified.”* Qualified Dependent Care Expenses do not include the following:
- (1) Amounts paid to a child of the Participant who is under age 19;
  - (2) Amounts paid to an individual for whom the Participant or the Participant’s spouse is entitled to an exemption under Code §151(c); and
  - (3) Amounts paid to a dependent care center that is not a Dependent Care Center as defined in Section 2.02(d) below.
- (b) *Special Rule for Services Performed Outside the Home.* Amounts paid for services performed outside the Participant’s household are not Qualified Dependent Care Expenses unless the expenses are for a Dependent as defined in Sections 2.02(c)(1) or 2.02(c)(2) below who spends at least eight (8) hours each day in the Participant’s home.
- (c) *Dependent.* For purposes of this DCAP benefit, the term "Dependent" means an individual meeting one of the following:
- (1) Under the age of 13 who is a dependent of the Participant and for whom the Participant is entitled to an exemption under Code §151(c); or
  - (2) A dependent or spouse of the Participant who is physically or mentally incapable of self care.
- (d) *Dependent Care Center.* The term "Dependent Care Center" means a facility, organized and operated in compliance with all applicable laws and regulations, for care of more than six (6) persons, including one (1) or more Dependents of the Participant, other than persons who reside there and which facility receives a fee, payment or grant for providing services for any of the six (6) individuals regardless of whether the facility operates at a profit.

Section 2.03 Reimbursement. The Employer will reimburse a Participant for his or her Qualified Dependent Care Expenses incurred by the Participant during the Plan Year subject to the other limitations of this DCAP. The Employer will only reimburse for Qualified Dependent Care Expenses incurred while the Employee participated in the DCAP benefit under the Cafeteria Plan.

Section 2.04 Reimbursable Qualified Dependent Care Expenses. Reimbursable Qualified Dependent Care Expenses do not include:

- (a) Education expenses for a child in the first grade or above;

- (b) Overnight care at a convalescent nursing home for a Dependent;
- (c) Overnight camp;
- (d) Expenses for lessons, tutoring or transportation;
- (e) Expenses paid through another policy or DCAP of the Participant or the Participant's spouse;  
or
- (f) Expenses incurred before the Participant elected to participate in the DCAP benefit.

Section 2.05 Maximum Amount of Reimbursement. The maximum amount of reimbursement during a Plan Year may not exceed the lesser of the exclusion amount or the earned income limitation. The exclusion amount for any Plan Year is \$5,000 (\$2,500 if a married person filing a separate return). The earned income limitation is the earned income of an unmarried Participant or, for a married Participant, the lesser of the earned income of the Participant or the Participant's spouse. The Claims Administrator will determine earned income pursuant to Code §32(c)(2). In no event will the Employer reimburse more than the dollar amount elected by the Participant. Additionally, in no event will the Employer reimburse more than the dollar amount actually credited to the Participant's DCAP for the year minus amounts previously reimbursed for the year.

Section 2.06 Withholding - Accounting. The Employer will establish and maintain a DCAP for each Participant who has elected to receive the DCAP benefit under the Cafeteria Plan. The Employer will credit to the Participant's DCAP an amount of the Participant's Compensation which he or she elects to reduce. The amounts credited to the Participant's DCAP are the property of the Employer until the Employer actually makes reimbursement. The Employer will debit a Participant's DCAP for the amount of the reimbursement made to the Participant. A Participant's DCAP will never exceed the maximum amount specified in Section 2.05 above.

Section 2.07 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's DCAP for any Plan Year to reimburse the Participant for Qualified Dependent Care Expenses. If any balance remains in the Participant's DCAP for any Plan Year after the Employer has made all reimbursements for the Plan Year, the Participant will forfeit the unused amount.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE III CLAIMS PROCEDURES**

Section 3.01 When to File a Claim. Subject to Section 4.01 the Participant must submit the application for reimbursement for expenses for a Plan Year not later than ninety (90) days after February 28 of each Plan Year.

Section 3.02 How to Submit Claims. A Participant desiring to be reimbursed for Qualified Dependent Care Expenses must make a claim for reimbursement by completing the application form provided by the Claims Administrator. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:

- (a) The amount and date of services rendered and the nature of each expense with respect to which a benefit is requested;
- (b) The name of the person, organization or entity to which the expense was or is to be paid;
- (c) The signature of the daycare provider; and
- (d) Such other information as the Claims Administrator may from time to time require.

Such application shall be accompanied by bills, invoices, receipts or other statements or certifications showing the amounts of such expenses, together with any additional documentation which the Employer may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Claims may be filed by the Participant or by the Participant's duly authorized representative. Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed

Section 3.03 Who Decides Claims. AFLAC will act as Claims Administrator with respect to any claims for benefits under this DCAP. AFLAC is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section 3.04 Limitation on Reimbursements with Respect to Certain Participants. No more than 25% of the total amounts reimbursed from all dependent care assistance accounts maintained by all Participants under this DCAP during any Plan Year may be reimbursed with respect to the class of individuals who own more than 5% of the stock of the Employer (or their spouses or dependents). Notwithstanding any other provision of this DCAP, the Claims Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated employee (within the meaning of Code §414(g)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with the restriction described in the preceding sentence or with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 2.07 above.

Section 3.05 Time Frame for Deciding Claims. The claim for reimbursement shall be approved or denied within a reasonable period (but no later than 90 days) after receipt of the claim by the Claims

Administrator. The initial 90-day period begins at the time the claim is filed whether or not all the necessary information for determining the claim is provided at that time.

Section 3.06 Extension of Time Frame for Deciding Claims. Notwithstanding Section 3.05 above, if the Claims Administrator determines that special circumstances require an extension of time (up to 90 days from the end of the initial 90-day period) for processing the claim for reimbursement, written notice of the extension shall be furnished to the Participant before the end of the initial 90-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Section 3.07 Notification Regarding the Claim Decision. If any claim for reimbursement of expenses under this DCAP is denied, in whole or in part, then the Claims Administrator shall furnish the Participant written notice within the applicable time periods described in 3.05 or 3.06 above:

- (a) Setting forth the reason for the denial;
- (b) Making reference to pertinent DCAP provisions upon which the denial is based;
- (c) Describing any additional material or information from the Participant which is necessary and why; and
- (d) Explaining the claim review procedure and the applicable time frames set forth herein.

Section 3.08 Right to Appeal the Decision. Within sixty (60) days after receipt of the notification of the denial to reimburse an expense, the Participant may request in writing a review of the denial by the Claims Administrator.

Section 3.09 Time Frame for Deciding Appeal. Subject to 3.10 below, the Claims Administrator shall render a decision on review of a denied claim within a reasonable period of time, but no later than sixty (60) days after receipt of the request for review hereunder unless special circumstances require an extension of time.

This 60-day period begins at the time an appeal is filed without regard to whether all the information necessary to determine on review whether an expense is reimbursable accompanies the filing. However, if an extension is required, as described below, due to the Participant's failure to submit necessary information, the period of time for making the determination shall be tolled from the date on which the notification of extension is sent to the Participant until the date on which the Participant responds to the request.

Section 3.10 Sixty (60) Day Extension of Time. If the Claims Administrator determines that special circumstances require an extension of time (up to 60 days from the end of the initial 60-day period) for processing the claim, written notice shall be furnished to the Participant before the end of the initial 60-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on appeal.

Section 3.11 Decision on Appeal. In the case of an adverse decision on appeal, the Claims Administrator shall send the Participant a notification:

- (a) Setting forth the reason for the denial;

- (b) Making reference to pertinent DCAP provisions upon which the denial is based;
- (c) Stating the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- (d) Explaining any voluntary appeals procedures and the Participant's right to information regarding these procedures, if any.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV**  
**TERMINATION OF DEPENDENT CARE ASSISTANCE PLAN**

Section 4.01 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this DCAP on the earlier of the following dates:

- (1) The date on which this DCAP terminates; or
- (2) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this DCAP terminates on the above date, coverage or benefits under the Pre-Tax Benefits may continue if and to the extent provided by such Pre-Tax Benefits.

If a Participant ceases to participate in this DCAP for any reason, the Participant's election to receive reimbursements for Qualified Dependent Care Expenses terminates on that date. A Participant may receive reimbursement only for Qualified Dependent Care Expenses incurred within the same DCAP Year and only during the period that the Participant was a Participant in this DCAP. If a Participant ceases participation under this DCAP, the Participant must apply for reimbursement in accordance with Article III through the end of the Plan Year for claims dated prior to the Participant's termination date.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V**  
**TERMINATION AND AMENDMENT OF THE DCAP**

The Employer may amend or terminate this DCAP at any time by written instrument duly adopted by the Employer.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE VI MISCELLANEOUS

Section 6.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 6.02 Employment Not Guaranteed. Nothing contained in this DCAP or in any other plan which is a part of the DCAP, or any modification or amendment to this DCAP, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Claims Administrator, except as expressly provided by this DCAP.

Section 6.04 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this DCAP is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this DCAP, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 6.05 Information. The Claims Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this DCAP.

Section 6.06 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this DCAP unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 6.07 Named Fiduciary. The named fiduciary of this DCAP shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this DCAP.

Section 6.08 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;
- (b) The amounts the Participant has elected to defer into a plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this DCAP or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

Section 6.09 No Guarantee of Tax Consequences. Neither the Claims Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this DCAP will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 6.10 Nonassignability. The right of any Participant to receive any benefits under this DCAP is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 6.11 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the DCAP due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the DCAP on a prospective basis only.

Section 6.12 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this DCAP, and then only to the extent that the benefits payable under the Component Benefit Plans are payable solely from the assets of the Employer.

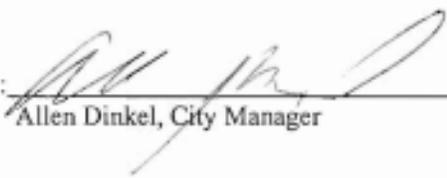
Section 6.13 Separate Liability. No fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this DCAP, by the Code, or by any regulations or rulings issued under the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this DCAP unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 6.14 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this DCAP except to the extent superseded by Federal law.

*[The remainder of this page intentionally left blank.]*

IN WITNESS WHEREOF, the Employer adopts this Vision Plan effective the 28<sup>th</sup> day of February, 2009.

**CITY OF ABILENE**

By:   
Allen Dinkel, City Manager

**CITY OF ABILENE**  
**AFLAC PRE-TAX PLAN**

**CITY OF ABILENE  
AFLAC PRE-TAX PLAN**

City of Abilene (“Employer”) adopts this AFLAC Pre-Tax Plan (“AFLAC Pre-Tax Plan”) for the benefit of its Eligible Employees. This AFLAC Pre-Tax Plan is an amendment and restatement of the Plan originally adopted effective March 1, 2001, as subsequently amended and restated effective March 1, 2010. This AFLAC Pre-Tax Plan is available through the City of Abilene Cafeteria Plan (“Cafeteria Plan”). Any term used in the Cafeteria Plan has the same meaning in this AFLAC Pre-Tax Plan, unless inconsistent with the provisions of this AFLAC Pre-Tax Plan.

**ARTICLE I  
INTRODUCTION**

Section 1.01     Name of Plan. The name of this Plan is the City of Abilene AFLAC Pre-Tax Plan.

Section 1.02     Purpose of Plan. The purpose of this Plan is to provide eligible Employees with insurance benefits.

Section 1.03     Plan Operation. This Plan shall continue without interruption and may be reviewed and amended from time to time.

Section 1.04     Character of Benefits Provided. This AFLAC Pre-Tax Plan does not provide medical treatment or advice. It merely pays for the cost of selected benefits as described in, and in accordance with, the provisions of the individual policies. The fact that a particular medical service may not be eligible for reimbursement under this AFLAC Pre-Tax Plan does not mean that a Participant or other person who is covered under this AFLAC Pre-Tax Plan should not receive that service.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE II**  
**ELIGIBILITY AND PARTICIPATION**

Section 2.01 Eligibility to Participate. Each Eligible Employee of the Employer shall become a Participant in this AFLAC Pre-Tax Plan on the first day of the first month coincident with or next following completion of one day of active employment with the Employer.

Section 2.02 Employees Changing from Part-Time to Full-Time Employment. Each Employee who is not an Eligible Employee, but who has completed one day of continuous, active employment with the Employer, becomes eligible to participate in this AFLAC Pre-Tax Plan on the first day of the month coincident with or next following the date on which he or she becomes an Eligible Employee.

Section 2.03 Election to Participate. If an Eligible Employee wishes to participate in this AFLAC Pre-Tax Plan, the Employee must complete the benefit election form provided by the Plan Administrator and make an election under the Cafeteria Plan to pay the applicable premium under this AFLAC Pre-Tax Plan. An Employee becomes a Participant in this AFLAC Pre-Tax Plan on the date specified on the Employee's benefit election form, provided the form has been properly completed and returned to the Plan Administrator, or the date the employee becomes eligible to participate in this AFLAC Pre-Tax Plan, whichever is later.

Section 2.04 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (c) The date on which this AFLAC Pre-Tax Plan terminates.

*[The remainder of this page is intentionally left blank.]*

### **ARTICLE III BENEFITS**

Section 3.01 Benefits Provided under Individual Policies. Under the AFLAC Pre-Tax Plan, the Participant may choose to receive benefits under one or more of the following policies of insurance:

- (a) *Cancer Plan.* Benefits under this Cancer Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.
- (b) *Personal Accident Plan.* Benefits under this Personal Accident Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.
- (c) *Personal Recovery Plus Plan.* Benefits under the Personal Recovery Plus Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.
- (d) *Personal Intensive Care Plan.* Benefits under this Personal Intensive Care Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

Section 3.02 Election to Participate. If an Eligible Employee wishes to participate in this AFLAC Pre-Tax Plan, the Employee must complete the benefit election form provided by the Plan Administrator and if necessary, elect, in accordance with the terms of the Cafeteria Plan, to reduce the Employee's Compensation in the amount of the applicable premium under Section 3.03.

Section 3.03 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the individual policies. Under those agreements, AFLAC may change the premiums from time to time. The Employer will designate for each Plan Year the pre-tax portion of the monthly premium for which the responsibility for payment will fall upon the Participant. A Participant who is self-employed within the meaning of Section 401(c)(1) of the Code or who is treated as a partner under Section 1372 of the Code must pay his or her portion of the premium on an *after-tax* basis.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV  
ADMINISTRATION OF THE AFLAC PRE-TAX PLAN**

Section 4.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this AFLAC Pre-Tax Plan. The Plan Administrator has full discretionary authority to administer this AFLAC Pre-Tax Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret this AFLAC Pre-Tax Plan, and to decide all questions concerning this AFLAC Pre-Tax Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this AFLAC Pre-Tax Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this AFLAC Pre-Tax Plan.

Section 4.02 Claims Administration. AFLAC will act as Claims Administrator with respect to any claim for benefits under this AFLAC Pre-Tax Plan. AFLAC is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V**  
**TERMINATION AND AMENDMENT OF THE AFLAC PRE-TAX PLAN**

The Employer may amend or terminate this AFLAC Pre-Tax Plan at any time by written instrument duly adopted by the Employer.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE VI MISCELLANEOUS

Section 6.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 6.02 Employment Not Guaranteed. Nothing contained in this AFLAC Pre-Tax Plan or in any other plan which is a part of the AFLAC Pre-Tax Plan, or any modification or amendment to this AFLAC Pre-Tax Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this AFLAC Pre-Tax Plan.

Section 6.03 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this AFLAC Pre-Tax Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this AFLAC Pre-Tax Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 6.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this AFLAC Pre-Tax Plan.

Section 6.05 Limitation on Liability. A AFLAC Pre-Tax Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this AFLAC Pre-Tax Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 6.06 Named Fiduciary. The named fiduciary of this AFLAC Pre-Tax Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this AFLAC Pre-Tax Plan.

Section 6.07 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;
- (b) The amounts the Participant has elected to defer into a plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this AFLAC Pre-Tax Plan or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's coverage prior to deducting any other amounts.

Section 6.08 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this AFLAC Pre-Tax Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant.

Section 6.09 Nonassignability. The right of any Participant to receive any benefits under this AFLAC Pre-Tax Plan is not subject to alienation or assignment and is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 6.10 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the AFLAC Pre-Tax Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the AFLAC Pre-Tax Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the AFLAC Pre-Tax Plan on a retroactive basis.

Section 6.11 Return of Premium. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section 6.12 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this AFLAC Pre-Tax Plan, and then only to the extent that the benefits payable under the Component Benefit Plans are payable solely from the assets of the Employer.

Section 6.13 Separate Liability. No fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this AFLAC Pre-Tax Plan, by the Code, or by any regulations or rulings issued under the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this AFLAC Pre-Tax Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 6.14 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this AFLAC Pre-Tax Plan except to the extent superseded by Federal law.

*[The remainder of this page is intentionally left blank.]*

IN WITNESS WHEREOF, the Employer adopts this amended and restated AFLAC Pre-Tax Plan effective the 1<sup>st</sup> day of March, 2010.



City of Abilene

By: Penny L. Soukup, CMC  
Penny L. Soukup, CMC  
City Clerk/Human Resource Manager

**CITY OF ABILENE**  
**AFLAC AFTER-TAX PLAN**

**CITY OF ABILENE  
AFLAC AFTER-TAX PLAN**

City of Abilene (“Employer”) adopts this amended and restated AFLAC After-Tax Plan (“AFLAC After-Tax Plan”) for the benefit of its Eligible Employees. This AFLAC After-Tax Plan is an amendment and restatement of the AFLAC After-Tax Plan originally adopted effective March 1, 2001, as subsequently amended and restated effective March 1, 2010. The purpose of this AFLAC After-Tax Plan is to provide Eligible Employees with insurance benefits.

**ARTICLE I  
DEFINITIONS**

Section 1.01 “Claims Administrator” means the Plan Administrator, unless the Employer retains another person to serve as the claims fiduciary for this AFLAC After-Tax Plan with the authority to grant or deny claims for benefits.

Section 1.02 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

Section 1.03 “Effective Date” means the original date on which this AFLAC After-Tax Plan took effect, which date is March 1, 2001; provided, however, that if this AFLAC After-Tax Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 1.04 “Eligible Employee” means an Employee, other than a Temporary Employee, actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding thirty (30) hours. Such status will be deemed to continue during any paid leave of absence approved by the Employer. An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two (2) weeks or less.

Section 1.05 “Employee” means an individual employed by the Employer, including any individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or who is treated as a partner under Section 1372 of the Code. The term “Employee” excludes those persons covered by a collective bargaining agreement and those persons classified by the Employer on its payroll records as “leased employees” as that term is used in Section 414(n) of the Code.

Section 1.06 “Employer” means City of Abilene

Section 1.07 “Participant” means an Employee who participates in this AFLAC After-Tax Plan in accordance with Article II.

Section 1.08 “Plan Administrator” means the Employer. The Employer may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this AFLAC After-Tax Plan in a manner consistent with the terms of this Plan.

Section 1.09 “Plan Year” means the fiscal year of this AFLAC After-Tax Plan, the twelve (12) consecutive month period ending on the last day of February.

Section 1.10 “Temporary Employee” means an Employee who is employed for a limited time period not exceeding 120 consecutive days.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE II**  
**ELIGIBILITY AND PARTICIPATION**

Section 2.01 Eligibility to Participate. Each Eligible Employee of the Employer shall become a Participant in this AFLAC After-Tax Plan on the first day of the first month coincident with or next following completion of one day of active employment with the Employer.

Section 2.02 Employees Changing from Part-Time to Full-Time Employment. Each Employee who is not an Eligible Employee, but who has completed one day of continuous, active employment with the Employer, becomes eligible to participate in this AFLAC After-Tax Plan on the first day of the month coincident with or next following the date on which he or she becomes an Eligible Employee.

Section 2.03 Election to Participate. If an Eligible Employee wishes to participate in this AFLAC After-Tax Plan, the Employee must complete the benefit election form provided by the Plan Administrator and pay the applicable premium under this AFLAC After-Tax Plan. An Employee becomes a Participant in this AFLAC After-Tax Plan on the date specified on the Employee's benefit election form, provided the form has been properly completed and returned to the Plan Administrator, or the date the employee becomes eligible to participate in this AFLAC After-Tax Plan, whichever is later.

Section 2.04 Termination of Participation. A Participant ceases to be a Participant as of the earliest of:

- (a) The last day of the month coincident with or next following the date on which the Participant terminates employment with the Employer;
- (b) The last day of the month coincident with or next following the date on which the Participant ceases to be an Eligible Employee; or
- (c) The date on which this AFLAC After-Tax Plan terminates.

*[The remainder of this page is intentionally left blank.]*

### **ARTICLE III BENEFITS**

Section 3.01 Benefits Provided under Individual Policies. Under the AFLAC After-Tax Plan, the Participant may choose to receive benefits in one or more of the following policies of insurance:

- (a) *Short Term Disability Plan.* Benefits under this Short Term Disability Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

Section 3.02 Cost of Coverage. The Participant's monthly premiums are determined pursuant to the individual policies. Under that agreement, AFLAC may change the premiums from time to time. The Employee is required to pay 100% of the monthly premium cost on an after-tax basis.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV  
ADMINISTRATION OF THE AFLAC AFTER-TAX PLAN**

Section 4.01 Plan Administration. The Employer, as Plan Administrator, is charged with supervision of the administration of this AFLAC After-Tax Plan. The Plan Administrator has full discretionary authority to administer this AFLAC After-Tax Plan in all respects, including the right to make and enforce rules and regulations it deems necessary, to interpret the AFLAC After-Tax Plan, and to decide all questions concerning this AFLAC After-Tax Plan and its administration, including all questions of Employee eligibility. Except as otherwise provided by law, all decisions of the Plan Administrator are final and binding on all parties. The Plan Administrator shall keep all such books, accounts, records and other data as may be necessary for the proper administration of this AFLAC After-Tax Plan. The Plan Administrator may appoint such agents, attorneys, accountants, consultants, Claims Administrators and any other persons as are needed or required for proper administration of this AFLAC After-Tax Plan.

Section 4.02 Claims Administration. AFLAC will act as Claims Administrator with respect to any claim for benefits under this AFLAC After-Tax Plan. AFLAC is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V**  
**TERMINATION AND AMENDMENT OF THE AFLAC AFTER-TAX PLAN**

The Employer may amend or terminate this AFLAC After-Tax Plan at any time by written instrument duly adopted by the Employer.

*[The remainder of this page is intentionally left blank.]*

## ARTICLE VI MISCELLANEOUS

Section 6.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 6.02 Employment Not Guaranteed. Nothing contained in this AFLAC After-Tax Plan, or any modification or amendment to this AFLAC After-Tax Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant or beneficiary any right to continue employment, any legal or equitable right against the Employer, or Employees of the Employer, or its agents, or against the Plan Administrator, except as expressly provided by this AFLAC After-Tax Plan.

Section 6.03 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any employee to whom fiduciary responsibility with respect to this AFLAC After-Tax Plan is allocated or delegated, from and against any and all liabilities, costs and expenses incurred by any such employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities and obligations under this AFLAC After-Tax Plan, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 6.04 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this AFLAC After-Tax Plan.

Section 6.05 Limitation on Liability. A plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this AFLAC After-Tax Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 6.06 Named Fiduciary. The named fiduciary of this AFLAC After-Tax Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this AFLAC After-Tax Plan.

Section 6.07 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

- (a) Taxes required to be withheld from the Participant's compensation;
- (b) The amounts the Participant has elected to defer into a plan maintained by the Employer;
- (c) The salary reductions elected by the Participant under this plan or under any similar plan maintained by the Employer; and
- (d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's coverage prior to deducting any other amounts.

Section 6.08 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the AFLAC After-Tax Plan due to the person's classification as an independent contractor (or Temporary Employee) and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the AFLAC After-Tax Plan on a prospective basis only.

Section 6.09 Return of Premium. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section 6.10 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise.

Section 6.11 Separate Liability. No fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this AFLAC After-Tax Plan, by the Code, or by any regulations or rulings issued under the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this AFLAC After-Tax Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 6.12 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this AFLAC After-Tax Plan except to the extent superseded by Federal law.

*[The remainder of this page intentionally left blank]*

IN WITNESS WHEREOF, the Employer adopts this amended and restated AFLAC After-Tax Plan effective the 1<sup>st</sup> day of March, 2010.

City of Abilene



By: Penny A. Soukup, CMC  
Penny Soukup, CMC  
City Clerk/Human Resource Manager

**CITY OF ABILENE**  
**AFLAC AFTER-TAX PLAN**  
**Summary Plan Description**

**CITY OF ABILENE  
AFLAC AFTER-TAX PLAN  
SUMMARY PLAN DESCRIPTION  
TABLE OF CONTENTS**

1. General .....	1
2. Identification of Plan .....	1
3. Type of Plan .....	1
4. Plan Administrator/Agent for Service of Legal Process .....	1
5. Eligibility .....	1
6. Plan Entry Date .....	1
7. Cost of Coverage .....	2
8. Terms of the Plan .....	2
9. Termination of Coverage .....	2
10. Claims Procedure .....	2
11. Claims Administration .....	3
12. Return of Premium .....	3
13. Right of Employer to Amend or Terminate .....	3
Appendix A - COBRA Notice Procedures .....	A-1

**CITY OF ABILENE  
AFLAC AFTER-TAX PLAN  
SUMMARY PLAN DESCRIPTION**

(1) **General.** The name, address, telephone number, and Federal tax identification number of the Employer are:

**City of Abilene  
P.O. Box 519  
Abilene, Kansas 67410  
(785) 263-2550  
EIN: 48-6017973**

The Employer has established this welfare benefit plan to give eligible employees insurance benefits. This summary is a highlight of the important provisions of the plan. In the event there is a conflict between this summary and the plan itself, the terms of the plan will control. Upon request, you may obtain a copy of the plan from the Plan Administrator.

(2) **Identification of Plan.** The name of the plan is the City of Abilene AFLAC After-Tax Plan (“AFLAC After-Tax Plan”). The Employer has assigned number 504 as the plan number for the plan. The plan year is the period on which the plan maintains its records: March 1 through February 28.

(3) **Type of Plan.** The Employer sponsors short term disability benefits through individual policies with AFLAC.

(4) **Plan Administrator / Service of Process.** The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other participants information regarding your rights and benefits under the plan. The Plan Administrator may also be required to file various reports, forms and returns with the Department of Labor and with the Internal Revenue Service.

The name of the person designated as the Agent for Service of Legal Process is Allen Dinkel, whose address is the same as the Employer's address.

(5) **Eligibility.** To be eligible to participate in the AFLAC After-Tax Plan, the following conditions must be met:

- (a) ***Employee.*** You must be an individual employed by the Employer;
- (b) ***Regularly Scheduled Hours Per Week.*** Your regularly scheduled workweek must ordinarily equal or exceed thirty (30) hours per week. For purposes of this AFLAC After-Tax Plan, this is considered to be “full-time”;
- (c) ***One (1) Day of Active Employment.*** You must have completed one (1) day of active employment with the Employer; and
- (d) ***Not Excluded from Participation.*** You must not be excluded from participation. You are excluded from participation if you are (1) covered under a collective bargaining agreement; or (2) classified on the Employer’s payroll records as a “leased” employee.

(6) **Plan Entry Date.** If all of the eligibility conditions have been met and you have completed the appropriate enrollment form(s), you will enter the AFLAC After-Tax Plan on the next day.

*EXAMPLE #1.* You begin working as a full-time employee on March 15. You complete one (1) day of active employment with the Employer on March 16 and you enroll in the AFLAC After-Tax Plan using the form(s) provided by the Plan Administrator. You will automatically enter the AFLAC After-Tax Plan on March 16.

(7) **Cost of Coverage.** Your monthly premiums are determined pursuant to the individual policies. Under that agreement, AFLAC may change the premiums from time to time. You are required to pay 100% of the monthly premium cost on an after-tax basis.

(8) **Terms of the Plan.** The plan is governed by a separate plan document. Please refer to such document for information regarding specific terms and conditions of the plan. The following is a summary of the plan.

Once you satisfy the eligibility requirements in Section (5) and you enroll in the AFLAC After-Tax Plan, you will be insured under the individual policies with AFLAC. This contract provides insurance benefits for eligible employees. AFLAC has prepared materials which explain the benefits of the individual policies in detail. You should obtain a copy of those materials from the Plan Administrator.

AFLAC is obligated to pay the benefits provided under the individual policies. The Employer makes no promise and shall have no obligation to provide or pay benefits under the individual policies.

(9) **Termination of Coverage.** Your participation in the plan ends on whichever of the following dates occurs first:

- (a) The last day of the month in which you terminate your employment with the Employer;
- (b) The date in which your election to participate expires for the applicable policy or policies;
- (c) The last day of the month in which you are no longer an eligible employee; or
- (d) The day the Employer terminates the AFLAC After-Tax Plan.

Your coverage for benefits under the plan ends with the termination of your participation. However, you may be eligible for a conversion contract offered by AFLAC. Please refer to the individual policies for further details.

(10) **Claims Procedure.** AFLAC, as the Claims Administrator, is responsible for deciding all claims for benefits under the AFLAC After-Tax Plan.

If you have a claim for benefits, you should submit that claim to the Claims Administrator. In submitting the claim, you should follow the procedures that are in the benefits summary that was prepared by AFLAC.

Once a claim has been submitted, the Claims Administrator will decide that claim in accordance with its reasonable claims procedures. If the claim is approved, the Claims Administrator will pay the claim. If the claim is denied, in whole or in part, the Claims Administrator will send you a written notice explaining the specific reasons your claim was denied. If your claim was denied because you did not provide all of the information the Claims Administrator needed to decide the claim, the notice will describe the additional material or information the Claims Administrator might need and will give you the opportunity to provide that additional material or information. If your claim was denied, the notice will also give you information about your right to appeal the denial of your claim.

If your claim was denied, you will have the right to appeal the denial to the Claims Administrator. The Claims Administrator will decide your appeal in accordance with its reasonable claims procedures.

*If you do not appeal on time, you will lose your right to go to court. You must appeal the denial of a claim to the Claims Administrator and must give the Claims Administrator the opportunity to look at your claim a second time before you may file suit in a court of law.*

The claims procedures that are followed by the Claims Administrator are contained in the benefits summary that was prepared by AFLAC. This summary is being provided to you automatically, without charge, as a separate document. If you did not receive a copy of this summary, you should ask the Plan Administrator for a copy.

(11) **Claims Administration.** AFLAC will act as Claims Administrator with respect to any claim for benefits under this AFLAC After-Tax Plan. AFLAC is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the Group Contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

(12) **Return of Premium.** If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

(13) **Right of Employer to Amend or Terminate.** The Employer may amend or terminate the City of Abilene AFLAC After-Tax Plan at any time by written instrument signed by the City Manager of the Employer. Any change to the plan will be added to the plan document in writing and communicated to the participants.

\* \* \* \* \*

**CITY OF ABILENE  
HEALTH REIMBURSEMENT  
ARRANGEMENT PLAN**

**TABLE OF CONTENTS**

**ARTICLE I, INTRODUCTION**

Section 1.01 Establishment of HRA Plan ..... 1.1  
Section 1.02 Legal Status..... 1.1

**ARTICLE II, DEFINITIONS**

Section 2.01 Benefits ..... 2.1  
Section 2.02 Claims Administrator..... 2.1  
Section 2.03 COBRA..... 2.1  
Section 2.04 Code..... 2.1  
Section 2.05 [Reserved]..... 2.1  
Section 2.06 Compensation ..... 2.1  
Section 2.07 Dependent ..... 2.1  
Section 2.08 [Reserved]..... 2.1  
Section 2.09 Eligible Employee..... 2.1  
Section 2.10 Employee ..... 2.1  
Section 2.11 Employer..... 2.2  
Section 2.12 Employment Commencement Date ..... 2.2  
Section 2.13 Enrollment Form..... 2.2  
Section 2.14 ERISA ..... 2.2  
Section 2.15 FMLA ..... 2.2  
Section 2.16 [Reserved]..... 2.2  
Section 2.17 [Reserved]..... 2.2  
Section 2.18 Highly Compensated Individual ..... 2.2  
Section 2.19 HIPAA ..... 2.2  
Section 2.20 HRA ..... 2.2  
Section 2.21 HRA Account ..... 2.2  
Section 2.22 Medical Care Expenses..... 2.2  
Section 2.23 Medical Plan ..... 2.2  
Section 2.24 Open Enrollment Period ..... 2.3  
Section 2.25 Participant ..... 2.3  
Section 2.26 Period of Coverage ..... 2.3  
Section 2.27 Plan ..... 2.3  
Section 2.28 Plan Administrator..... 2.3  
Section 2.29 Plan Year..... 2.3  
Section 2.30 Privacy Officer..... 2.3  
Section 2.31 [Reserved]..... 2.3  
Section 2.32 QMCSO ..... 2.3  
Section 2.33 Related Employer ..... 2.3  
Section 2.34 Spouse..... 2.3  
Section 2.35 SPD ..... 2.3  
Section 2.36 [Reserved]..... 2.3  
Section 2.37 Suspension Election Form ..... 2.4  
Section 2.38 USERRA..... 2.4

**ARTICLE III, ELIGIBILITY AND PARTICIPATION**

Section 3.01 Eligibility to Participate ..... 3.1  
Section 3.02 Termination of Participation ..... 3.1  
Section 3.03 Participation Following Termination of Employment or Loss of Eligibility..... 3.1  
Section 3.04 FMLA and USERRA Leaves of Absence ..... 3.1  
Section 3.05 Non-FMLA and Non-USERRA Leaves of Absence ..... 3.2

**ARTICLE IV, METHOD AND TIMING OF ENROLLMENT**

Section 4.01 Enrollment When First Eligible ..... 4.1

**ARTICLE V, BENEFITS OFFERED AND METHOD OF FUNDING**

Section 5.01 Benefits Offered..... 5.1  
Section 5.02 Employer and Participant Contributions..... 5.1  
Section 5.03 Funding this HRA Plan ..... 5.1

**ARTICLE VI, HEALTH REIMBURSEMENT BENEFITS**

Section 6.01 Benefits ..... 6.1  
Section 6.02 Eligible Medical Care Expenses ..... 6.1  
Section 6.03 Maximum Benefits ..... 6.1  
Section 6.04 Establishment of Account ..... 6.2  
Section 6.05 No Carryover of Accounts ..... 6.2  
Section 6.06 Reimbursement Procedure ..... 6.2  
Section 6.07 Reimbursements After Termination of Employment..... 6.3  
Section 6.08 COBRA..... 6.3  
Section 6.09 [Reserved]..... 6.3  
Section 6.10 Compliance With Laws Applicable to Group Health Plans ..... 6.4  
Section 6.11 Coordination of Benefits..... 6.4

**ARTICLE VII, HIPAA PRIVACY AND SECURITY**

Section 7.01 Purpose and Effective Date..... 7.1  
Section 7.02 Prohibition Against Disclosing Protected Health Information to the Employer..... 7.1  
Section 7.03 Definitions ..... 7.1  
Section 7.04 Enrollment / Disenrollment Information ..... 7.3  
Section 7.05 Plan Administration Functions ..... 7.3  
Section 7.06 Conditions for Disclosure for Plan Administration Functions..... 7.4  
Section 7.07 Certification by the Employer..... 7.5  
Section 7.08 Adequate Separation Between the Employer and the HRA Plan ..... 7.6  
Section 7.09 Authorized Employees..... 7.6  
Section 7.10 Use Pursuant to an Authorization ..... 7.6  
Section 7.11 Consequences of Unauthorized Use of PHI or e-PHI..... 7.6

**ARTICLE VIII, APPEALS PROCEDURE**

Section 8.01 Procedure If Benefits Are Denied Under This HRA Plan ..... 8.1  
Section 8.02 Timeframe to Accept or Deny Claim..... 8.1  
Section 8.03 Denial Notice ..... 8.1  
Section 8.04 Internal Appeal of Denial of Claim ..... 8.1  
Section 8.05 Deadline for Filing Appeal ..... 8.2  
Section 8.06 Documents Upon Internal Appeal ..... 8.2  
Section 8.07 Notification of Decision on Internal Appeal..... 8.2  
Section 8.08 Information in Notice of Denial of Internal Appeal ..... 8.2  
Section 8.09 Right to External Review..... 8.3  
Section 8.10 External Appeal of Denied Claim..... 8.3  
Section 8.11 Deadline for Filing External Appeal..... 8.4  
Section 8.12 Notification of Decision on External Appeal..... 8.4

**ARTICLE IX, RECORDKEEPING AND ADMINISTRATION**

Section 9.01 Plan Administrator..... 9.1  
Section 9.02 Compensation of Plan Administrator..... 9.1  
Section 9.03 Effect of Mistake ..... 9.1  
Section 9.04 Fiduciary Liability ..... 9.1  
Section 9.05 Inability to Locate Payee ..... 9.1  
Section 9.06 Insurance Contracts..... 9.1  
Section 9.07 Powers of the Plan Administrator ..... 9.1  
Section 9.08 Provision for Third-Party Plan Service Providers..... 9.2  
Section 9.09 Reliance on Participant, Tables, etc..... 9.2

**ARTICLE X, GENERAL PROVISIONS**

Section 10.01 Amendment and Termination ..... 10.1  
Section 10.02 Code Compliance..... 10.1  
Section 10.03 Expenses ..... 10.1  
Section 10.04 Governing Law ..... 10.1  
Section 10.05 Headings ..... 10.1  
Section 10.06 Indemnification of Employer..... 10.1  
Section 10.07 No Contract of Employment..... 10.1  
Section 10.08 No Guarantee of Tax Consequences..... 10.1  
Section 10.09 Non-Assignability of Rights ..... 10.1  
Section 10.10 HRA Plan Provisions Controlling..... 10.2  
Section 10.11 Severability ..... 10.2

**CITY OF ABILENE  
HEALTH REIMBURSEMENT ARRANGEMENT PLAN**

**ARTICLE I  
INTRODUCTION**

Section 1.01 Establishment of Plan. The City of Abilene (the “Employer”) hereby establishes the City of Abilene Health Reimbursement Arrangement Plan (the “Plan”) effective March 1, 2012 (the “Effective Date”). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

Section 1.02 Legal Status. This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees’ gross income under Code § 105(b).

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE II DEFINITIONS**

Section 2.01 “Benefits” means the reimbursement benefits for Medical Care Expenses described under Article VI.

Section 2.02 “Claims Administrator” means Freedom Claims.

Section 2.03 “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Section 2.04 “Code” means the Internal Revenue Code of 1986, as amended.

Section 2.05 [Reserved]

Section 2.06 “Compensation” means the wages, salary or other remuneration paid to an Employee by the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan or a 403(b) or arrangements on behalf of the Participant, and does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.07 “Dependent” means any individual who is a dependent of the Participant as defined in Code § 105(b), with the following two exceptions:

- (a) Dependent children who are not disabled are only covered through the end of the month in which they turn age 26; and
- (b) Any child to whom Code § 152(e) applies, regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year, is treated as a dependent of both parents.

Notwithstanding the foregoing, the HRA Plan will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “Dependent.”

Section 2.08 [Reserved]

Section 2.09 “Eligible Employee” means an Employee eligible to participate in this Plan, as provided in Section 3.01.

Section 2.10 “Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include the following:

- (a) Any leased employee and reclassified employees. The reclassified employee exclusion applies to any person the Employer does not treat as an employee (including, but not limited to, independent contractors, persons the Employer pays outside of its payroll system and outsourced workers) for federal income tax withholding purposes under Code section 3401(a), irrespective of whether there is a binding determination that the individual is an Employee or a leased employee of the Employer;

- (b) Any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer;
- (c) Any employee covered under a collective bargaining agreement;
- (d) Any self-employed individual;
- (e) Any partner in a partnership; and/or
- (f) Any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be more-than-2% shareholder by virtue of the Code § 318 ownership attribution rules.

The term “Employee” does not include “former Employees” for the limited purpose of allowing continued eligibility for Benefits in accordance with Section 3.02.

Section 2.11 “Employer” means the City of Abilene.

Section 2.12 “Employment Commencement Date” means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

Section 2.13 “Enrollment Form” means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan.

Section 2.14 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

Section 2.15 “FMLA” means the Family and Medical Leave Act of 1993, as amended.

Section 2.16 [Reserved]

Section 2.17 [Reserved]

Section 2.18 “Highly Compensated Individual” means an individual defined under Code § 105(h), as amended, as a “highly compensated individual” or “highly compensated employee.”

Section 2.19 “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

Section 2.20 “HRA” means a health reimbursement arrangement as defined in IRS Notice 2002-45.

Section 2.21 “HRA Account” means the HRA Account described in Section 6.04.

Section 2.22 “Medical Care Expenses” has the meaning defined in Section 6.02.

Section 2.23 “Medical Plan” means the plan that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan) providing major medical type benefits.

Section 2.24 “Open Enrollment Period” with respect to a Plan Year means the calendar month of February in the year immediately preceding the Plan Year, or such other period as may be prescribed by the Plan Administrator, in which Eligible Employees enroll in welfare benefits.

Section 2.25 “Participant” means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

Section 2.26 “Period of Coverage” means the Plan Year, with the following exceptions:

- (a) For Employees who first become eligible to participate, “period of coverage” shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.01; and
- (b) For Employees who terminate participation, “period of coverage” shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.02.

A different Period of Coverage (e.g., monthly) may be established by the Plan Administrator and communicated to Participants.

Section 2.27 “Plan” means the City of Abilene Health Reimbursement Arrangement Plan (“HRA Plan”) as set forth herein and as amended from time to time.

Section 2.28 “Plan Administrator” means the Employer. The Employer may designate from time to time one or more individuals or other persons to carry out various administrative and other duties (such as claims administration) with respect to this HRA Plan in a manner consistent with the terms of this HRA Plan and ERISA.

Section 2.29 “Plan Year” means the 12-month period commencing each March 1 and ending on February 28, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

Section 2.30 “Privacy Officer” shall have the meaning described in 45 C.F.R §164.530(a).

Section 2.31 [Reserved]

Section 2.32 “QMCSO” means a qualified medical child support order, as defined in ERISA § 609(a).

Section 2.33 “Related Employer” means any employer affiliated with the City of Abilene, under Code § 414(b), (c), or (m), is treated as a single employer with the City of Abilene for purposes of Code § 105.

Section 2.34 “Spouse” means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

Section 2.35 “SPD” means the separate summary plan description describing the terms of this HRA Plan.

Section 2.36 [Reserved]

Section 2.37 “Suspension Election Form” means the form provided by the Plan Administrator for the purposes of allowing a Participant to suspend his or her HRA Account for a Plan Year.

Section 2.38 “USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

*[The remainder of this page is intentionally left blank.]*

### **ARTICLE III ELIGIBILITY AND PARTICIPATION**

Section 3.01 Eligibility to Participate. An individual is eligible to participate in this HRA Plan if the individual satisfies all of the following conditions:

- (a) *Employee.* The individual is an Employee;
- (b) *Regularly Scheduled to Work.* The individual is regularly scheduled to work twenty (20) or more hours per week; and
- (c) *Participation in Medical Plan.* The individual participates in one of the options under the Medical Plan other than a “high-deductible health plan” option.

Once an Employee has met the HRA Plan’s eligibility requirements, the Employee’s coverage will commence on the first day of the month coincident with or next following completion and submission to the Plan Administrator of an Enrollment Form.

Section 3.02 Termination of Participation. A Participant will cease to be a Participant in this HRA Plan upon the earlier of:

- (a) The termination of this HRA Plan; or
- (b) The date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis under Section 6.07.

Reimbursements from the HRA Account after termination of participation will be made pursuant to Section 6.07 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

Section 3.03 Participation Following Termination of Employment or Loss of Eligibility. If a Participant terminates his/her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same HRA Account balance that such individual had before termination. If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason, including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee must again enter the HRA Plan pursuant to Section 3.01 and the Employee’s HRA Account balance will be credited as a newly eligible Participant pursuant to Section 6.04.

Section 3.04 FMLA and USERRA Leaves of Absence. Notwithstanding any provision to the contrary in this HRA Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant’s Benefits on the same terms and conditions as if the Participant were still an active Employee.

Section 3.05 Non-FMLA and Non-USERRA Leaves of Absence. If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation as described above under Section 3.02.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IV**  
**METHOD AND TIMING OF ENROLLMENT**

Section 4.01 Enrollment When First Eligible. An Employee who first becomes eligible to participate in this HRA Plan will commence participation on the first day of the month coincident with or next following the date the eligibility requirements are satisfied, provided that an Enrollment Form is submitted to the Plan Administrator before participation commences. Once enrolled, the Employee's participation will continue month-to-month and year-to-year until the Employee's participation ceases pursuant to Section 3.02.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE V**  
**BENEFITS OFFERED AND METHOD OF FUNDING**

Sections 5.01 Benefits Offered. When an Eligible Employee becomes a Participant in accordance with Articles III and IV, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article VI. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

Section 5.02 Employer and Participant Contributions. The following describes the contributions under the HRA Plan:

- (a) *Employer Contributions.* The Employer shall provide the full amount of the HRA Accounts.
- (b) *Participant Contributions.* There are no Participant contributions for Benefits under the HRA Plan.
- (c) *No Contributions Under Cafeteria Plan.* Under no circumstances will the Benefits be provided through salary reduction contributions, Employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the HRA Plan.

Section 5.03 Funding this HRA Plan. All of the amounts payable under this HRA Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of a Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this HRA Plan may be made. There is not a trust or other fund from which Benefits are paid.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VI**  
**HEALTH REIMBURSEMENT BENEFITS**

Section 6.01 Benefits. The HRA Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA Account, as set forth and adjusted under Section 6.04.

Section 6.02 Eligible Medical Care Expenses. Under the HRA Account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

- (a) *Incurred.* Medical Care Expenses are incurred at the time the medical care or service giving rise to the expenses is furnished, and not when the individual incurring the expenses is formally billed for, charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the HRA Plan are not eligible.
- (b) *Participant's Share of the True Deductible Has Been Satisfied.* Before a medical care expense is eligible for reimbursement, the Participant must satisfy his/her portion of the Medical Plan deductible. The portion of the "true" deductible which is the Participant's responsibility to pay shall be determined by the Plan Administrator for each Plan Year.
- (c) *Medical Care Expenses Generally.* "Medical Care Expenses" means expenses incurred by a Participant or his or her Spouse or Dependents in meeting their deductible under the Medical Plan for medical care, as defined in Code § 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but shall not include expenses that are described in subsection (d) below. Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's HRA Account.
- (d) *Medical Care Expenses Exclusions.* "Medical Care Expenses" shall not include (1) health insurance premiums for individual policies or for any other group health plan (including a plan sponsored by the Employer); and (2) the expenses listed as exclusions under Appendix A to this HRA Plan. Notwithstanding the foregoing, an HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer.
- (e) *Cannot Be Reimbursed or Reimbursable from Another Source.* Medical Care Expenses can only be reimbursed to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Medical Plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VI.

Section 6.03 Maximum Benefits.

- (a) *Maximum Benefits.* The maximum dollar amount that may be credited to an HRA Account for an Employee who participates for an entire 12-month Period of Coverage is \$4,000. Unused amounts may not be carried over to the next Period of Coverage, as provided in Section 6.05.

- (b) *Changes.* For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Enrollment Form, the SPD or another document.
- (c) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code § 105(h), as may be determined by the Plan Administrator in its sole discretion.

Section 6.04 Establishment of Account. The Plan Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

- (a) *Crediting of Accounts.* A newly eligible Participant, such as a Participant who becomes covered under the HRA Plan on the 1<sup>st</sup> day of the Plan Year (i.e., was not enrolled in the prior Plan Year) or a Participant who becomes covered under the HRA Plan mid-Plan Year (e.g., a new hire who meets the eligibility conditions), will have his/her HRA Account credited with an amount equal to the applicable maximum dollar limit for the Period of Coverage.
- (b) *Debiting of Accounts.* A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's HRA Account under subsection (A) reduced by prior reimbursements debited under subsection (B).

Section 6.05 No Carryover of Accounts. If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Period of Coverage. Upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected as provided in Section 6.08. In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited.

Section 6.06 Reimbursement Procedure.

- (a) *Where to File Claims.* Any claim for Benefits which arises under the HRA Plan shall be filed with the Claims Administrator.
- (b) *Timing.* Within 30 days after receipt by the Claims Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Claims Administrator approves the claim), or the Claims Administrator will notify the Participant that his or her claim has been denied (see Section 8.01 regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

- (c) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Claims Administrator in such form as the Claims Administrator may prescribe, by no later than ninety (90) days following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:
- (1) The person or persons on whose behalf Medical Care Expenses have been incurred;
  - (2) The nature and date of the Expenses so incurred;
  - (3) The amount of the requested reimbursement; and
  - (4) A statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third-party showing that the Medical Care Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Claims Administrator may request.

- (d) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article VIII.

Section 6.07 Reimbursements After Termination of Employment. When a Participant ceases to be a Participant under Section 3.02, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his/her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the termination of participation, provided that the Participant (or the Participant's estate) files a claim within ninety (90) days following the close of the Plan Year in which the Medical Care Expense arose.

Section 6.08 COBRA. Notwithstanding any provision to the contrary in this HRA Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries, as that term is defined in COBRA), whose coverage terminates under the HRA Account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. At the beginning of each month in the Plan Year, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (i.e., the maximum annual reimbursement amount, divided by the number of months in that Plan Year) that is made available to similarly-situated non-COBRA beneficiaries. A premium for continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by COBRA.

Section 6.09 [Reserved]

Section 6.10 Compliance With Laws Applicable to Group Health Plans. Benefits shall be provided in compliance with COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

Section 6.11 Coordination of Benefits. Benefits under the HRA Plan are intended to pay Benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere and only to the extent that the deductible under the Medical Plan has not been satisfied. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this HRA Plan.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE VII  
HIPAA PRIVACY AND SECURITY**

**PART I  
PREAMBLE**

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

**PART II  
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER**

Section 7.02 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the HRA Plan and/or a health insurance issuer with respect to the HRA Plan may not disclose PHI to the Employer.

Section 7.03 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

- (a) “*Breach*” means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use or disclosure are excluded from the definition of a “breach:”
- (1) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the HRA Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the HRA Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;
  - (2) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the HRA Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and
  - (3) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.
- (b) “*De-identified Health Information*” means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

- (c) *“Electronic Media”* means:
- (1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or
  - (2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.
- (d) *“Electronic Protected Health Information”* (*“e-PHI”*) is PHI that is transmitted or maintained in electronic media.
- (e) *“Individually Identifiable Health Information”* means information for which each of the following conditions is met:
- (1) The information is created or received by a health care provider, a health plan (including a plan or a health insurance issuer), an employer, or a health care clearinghouse;
  - (2) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
  - (3) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.
- (f) *“Plan Administration Functions”* means administrative functions performed by the Employer on behalf of the HRA Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.
- (g) *“Protected Health Information (PHI)”* means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.
- (h) *“Security Incident”* (as defined in 45 CFR 164,304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- (i) *“Security Rule”* (as defined in 45 CFR 164,304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

- (j) “*Summary Health Information*” means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the HRA Plan and from which the identifying information listed in Section 164.514(b)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five digit ZIP code.
- (k) “*Unsecured PHI*” means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.04 Enrollment / Disenrollment Information. The HRA Plan and/or a health insurance issuer with respect to the HRA Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the HRA Plan.

Section 7.05 Plan Administration Functions. The HRA Plan and/or a health insurance issuer with respect to the HRA Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the HRA Plan. Such responsibilities may include the following:

- (a) Reviewing the performance of the HRA Plan, including the performance of any insurance companies providing group health coverage for the HRA Plan and the performance of any business associates of the HRA Plan;
- (b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any appeals that are filed with respect to claims that are denied in whole or in part;
- (c) Overseeing the coordination of Benefits and pursuing and/or responding to claims for subrogation;
- (d) Conducting cost management and planning related analysis, including the forecasting of expected healthcare costs based on current utilization of Benefits;
- (e) Detecting fraud or abuse;
- (f) Determining whether charges for services are appropriate or justified;
- (g) Requesting underwriting or premium rating and other activities related to the creation, renewal or replacement of a contract of health insurance;
- (h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the HRA Plan is self-insured in whole or in part;
- (i) Ensuring that the required premiums for the coverage provided under the HRA Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third-party service providers as may be necessary or appropriate;

- (j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;
- (k) Reporting corporate finances with respect to current and projected healthcare costs;
- (l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the HRA Plan in providing such information and only if the HRA Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and
- (m) Performing other functions as required to effectively offer Benefits under the HRA Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.05 is subject to the provisions of Section 7.06.

Section 7.06 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the HRA Plan and/or a health insurance issuer with respect to the HRA Plan pursuant to Section 7.05, the Employer agrees to do the following:

- (a) Not use or further disclose PHI or e-PHI other than as permitted or required by the HRA Plan document or as required by law;
- (b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;
- (c) Not use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;
- (d) Report to the HRA Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this HRA Plan to the extent it becomes aware of such information. If and as required by any applicable Department of Health and Human Services regulations, this reporting requirement will also include reporting to the HRA Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and the Department of Health and Human Services may be appropriately notified of the Breach as required by the regulations issued regarding breach notification;
- (e) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the HRA Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;
- (f) Make the PHI or e-PHI that it receives from the HRA Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his or her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;

- (g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;
- (h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;
- (i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the HRA Plan with HIPAA's medical privacy and security requirements;
- (j) If feasible, return or destroy all PHI or e-PHI received from the HRA Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (k) Ensure that adequate separation between the Employer and the HRA Plan exists, as set forth in more detail in Part III;
- (l) Provide a certification to the HRA Plan as required by Section 7.07; and
- (m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the HRA Plan, it will do the following:
  - (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;
  - (2) Ensure that any agents (including subcontractors) to whom it provides such e-PHI agrees to implement reasonable and appropriate security measures to protect the information; and
  - (3) Report to the HRA Plan any Security Incident of which it becomes aware.

Section 7.07 Certification by the Employer. In the absence of an authorization, the HRA Plan may not disclose any PHI or e-PHI to the Employer unless and until the HRA Plan is in receipt of a certification from the Employer. The Employer must certify in the certification that the HRA Plan has been amended to incorporate the provisions required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations. The Employer must further certify in the certification that the Employer agrees to the conditions of disclosure as set forth in Section 7.06 and in Part III.

**PART III**  
**ADMINISTRATIVE SAFEGUARDS**

Section 7.08 Adequate Separation Between the Employer and the HRA Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the HRA Plan except as set forth in this Part III of Article VII. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the “authorized employees” have access to e-PHI. Further, this Part III of Article VII does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this HRA Plan.

Section 7.09 Authorized Employees. The following Employees (“Authorized Employees”) are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the HRA Plan in order to provide Benefits to participants:

- Privacy Official
- Employees in the Employer’s Human Resources Department
- Employees in the Employer’s Office of General Counsel
- Any other class of employees designated in writing by the Privacy Official

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel’s support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the HRA Plan’s policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.10 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.11 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE VIII APPEALS PROCEDURE**

Section 8.01 Procedure If Benefits Are Denied Under This HRA Plan. If a claim for reimbursement under this HRA Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth below.

Section 8.02 Timeframe to Accept or Deny Claim. Within 30 days after the Claims Administrator's receipt of the claim, the Participant must be notified of the decision with regard to the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Administrator. The Claims Administrator is required to notify the Participant of the need for the extension and the time by which the Participant will receive a determination on his/her claim. If the extension is necessary because of the Participant's failure to submit the information necessary to decide the claim, then the Claims Administrator will notify the Participant regarding what additional information the Participant is required to submit, and the Participant will be given at least 45 days after such notice to submit the additional information. If the Participant does not submit the additional information, the Claims Administrator will make the decision based on the information that it has.

Section 8.03 Denial Notice. If the claim is denied, the notice that the Participant receives from the Claims Administrator will include the following information:

- (a) Information about the claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- (b) The specific reason for the denial;
- (c) A reference to the specific HRA Plan provision(s) on which the denial is based;
- (d) Any denial code (and its corresponding meaning) that was used in denying the claim;
- (e) A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary;
- (f) A description of the HRA Plan's review procedures and the time limits applicable to such procedures; and
- (g) If the Claims Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided free of charge upon request.

Section 8.04 Internal Appeal of Denial of Claim. If the Participant appeals a claim denial, the appeal must be in writing, must be provided to the Claims Administrator, and must include the following information:

- (a) Participant's name and address;

- (b) The fact that the Participant is disputing a denial of a claim or the Claims Administrator's act or omission;
- (c) The date of the notice that the Claims Administrator informed the Participant of the denied claim; and
- (d) The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Administrator's act or omission.

The Participant should also include any documentation that he/she has not already provided to the Claims Administrator.

**Section 8.05 Deadline for Filing Internal Appeal.** An internal appeal must be delivered to the Claims Administrator within 180 days after receiving the denial notice or the Claims Administrator act or omission. *If the Participant does not file the appeal within this 180-day period, the Participant shall lose his/her right to appeal.* The appeal will be heard and decided by the Claims Administrator.

**Section 8.06 Documents Upon Internal Appeal.** Anytime before the appeal deadline, the Participant may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claims Administrator. The HRA Plan is required to provide the Participant with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing the Participant's internal appeal, the Claims Administrator will take into account all relevant documents, records, comments, and other information that the Participant has provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Claims Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that the Participant provided, the Participant shall be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claims Administrator's notice of final internal adverse benefit determination. If the Claims Administrator identifies a new or additional reason for denying the Participant's claim, said new or additional reason shall be disclosed to the Participant and the Participant shall be given a reasonable opportunity to respond to said new or additional reason before the due date for the Claims Administrator's notice of final internal adverse benefit determination.

The internal appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination, nor an individual whose terms and conditions of employment are affected by the results of his/her decision.

If the internal appeal determination will be based on the medical judgment of a health care professional retained by the Claims Administrator, the health care professional retained for purposes of the internal appeal shall not be or be a subordinate to an individual who was consulted in connection with the determination that is being appealed.

**Section 8.07 Notification of Decision on Internal Appeal.** The Claims Administrator must notify the Participant of the decision on internal appeal within 60 days after receipt of the Participant's request for review.

Section 8.08 Information in Notice of Denial of Internal Appeal. If the internal appeal is denied, the notice that the Participant receives from the Claims Administrator shall include the following information:

- (a) Information about the claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available.;
- (b) The specific reason for the denial upon review;
- (c) A reference to the specific HRA Plan provision(s) on which the denial is based;
- (d) Any denial code (and its corresponding meaning) that was used in denying the claim;
- (e) A statement providing that the Participant is required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
- (f) If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to the Participant free of charge upon request; and
- (g) A statement of the Participant's right to bring an external appeal or a civil action under ERISA § 502(a).

Section 8.09 Right to External Review. The Participant has a right to an external review of the Claims Administrator's denial of the Participant's internal appeal unless the Benefit denial was based on the failure of the Participant's, his/her Spouse's, or his/her Dependent's failure to meet the HRA Plan's eligibility requirements.

Section 8.10 External Appeal of Denied Claim.

- (a) *Determination Whether Claim is Eligible for External Review.* Within 5 days after receiving a Participant's request for external review, the Plan Administrator shall determine whether the claim is eligible for review under the external review process. This determination is based on whether:
  - (1) The Participant is or was covered under the HRA Plan at the time the claim was made or incurred;
  - (2) The denial relates to the Participant's failure to meet the HRA Plan's eligibility requirements;
  - (3) The Participant has exhausted the HRA Plan's internal claims and appeal procedures; and
  - (4) The Participant has provided all the information required to process an external review.

Within one (1) business day after completion of this preliminary review, the Plan Administrator will provide written notification to the Participant of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Plan Administrator will notify the Participant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the Plan Administrator's notice will describe the information needed to complete it. The Participant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

- (b) *Assignment to Independent Review Organization for External Review.* If the Participant's request is eligible for the external review process, the HRA Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Participant, in writing, that the request for external review has been accepted. The notice will include a statement that the Participant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the HRA Plan. The HRA Plan may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.
- (c) *Evaluation of Claim by IRO.* If the HRA Plan does not reverse its denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as the following:
  - (1) The Participant's medical records;
  - (2) The attending health care professional's recommendation;
  - (3) Reports from appropriate health care professionals and other documents submitted by the HRA Plan or issuer, Participant, or Participant's treating provider;
  - (4) The terms of the HRA Plan;
  - (5) Appropriate practice guidelines;
  - (6) Any applicable clinical review criteria developed and used by the HRA Plan; and
  - (7) The opinion of the IRO's clinical reviewer.

Section 8.11 Deadline for Filing External Appeal. An external appeal must be delivered to the IRO within four (4) months of the date the Participant was served with the Claims Administrator's response to the Participant's internal appeal. *If the Participant does not file the appeal within this 4-month period, the Participant shall lose his/her right to appeal.*

Section 8.12 Notification of Decision on External Appeal. The IRO must notify the Participant and the Claims Administrator of its decision on external appeal within 45 days after receipt of the Participant's request for external review. The IRO's decision notice must contain the following:

- (a) A general description of the reason for the external review, including information sufficient to identify the claim;
- (b) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- (c) References to the evidence or documentation the IRO considered in reaching its decision;
- (d) Discussion of the principal reason(s) for the IRO's decision;
- (e) A statement that the determination is binding (except to the extent other remedies may be available under State or Federal law); and
- (f) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

In addition, if the Participant resides in a county where 10% or more of the population does not speak English, the notice must be set forth in the applicable non-English language.

*[The remainder of this page is intentionally left blank.]*

**ARTICLE IX  
RECORDKEEPING AND ADMINISTRATION**

Section 9.01 Plan Administrator. The administration of the HRA Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this HRA Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this HRA Plan without discrimination among them. The Plan Administrator has appointed Freedom Claims Management, Inc. to act as Claims Administrator.

Section 9.02 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an Employee of the Employer shall serve without Compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

Section 9.03 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the HRA Plan. Such action by the Plan Administrator may include withholding of any amounts due to the HRA Plan or the Employer from Compensation paid by the Employer.

Section 9.04 Fiduciary Liability. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this HRA Plan.

Section 9.05 Inability to Locate Payee. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the HRA Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that such payment first became due.

Section 9.06 Insurance Contracts. The Employer shall have the right (1) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the HRA Plan; and (2) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the HRA Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

Section 9.07 Powers of the Plan Administrator. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the HRA Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- (a) To construe and interpret this HRA Plan, including all possible ambiguities, inconsistencies and omissions in the HRA Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this HRA Plan (provided that, notwithstanding the first paragraph in this Section, the Claims Administrator shall exercise such exclusive power with respect to an appeal of a claim under Section 8.01);
- (b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this HRA Plan;
- (c) To prepare and distribute information explaining this HRA Plan and the Benefits under this HRA Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this HRA Plan;
- (e) To furnish each Employee and Participant with such reports with respect to the administration of this HRA Plan as the Plan Administrator determines to be reasonable and appropriate;
- (f) To receive, review and keep on file such reports and information concerning the Benefits covered by this HRA Plan as the Plan Administrator determines from time to time to be necessary and proper;
- (g) To appoint and employ such individuals or entities to assist in the administration of this HRA Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) To sign documents for the purposes of administering this HRA Plan, or to designate an individual or individuals to sign documents for the purposes of administering this HRA Plan;
- (i) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (j) To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this HRA Plan and to meet any applicable disclosure and reporting requirements.

Section 9.08 Provision for Third-Party Plan Service Providers. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the HRA Plan. Unless otherwise provided in the service agreement, obligations under this HRA Plan shall remain the obligation of the Employer.

Section 9.09 Reliance on Participant, Tables, etc. The Plan Administrator may rely upon the information submitted by a Participant as being proper under the HRA Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

*[The remainder of this page is intentionally left blank.]*

## **ARTICLE X GENERAL PROVISIONS**

Section 10.01 Amendment and Termination. This HRA Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this HRA Plan at any time for any reason by resolution of the City Commission or by any person or persons authorized by the City Commission to take such action.

Section 10.02 Code Compliance. It is intended that this HRA Plan meet all applicable requirements of the Code, and of all regulations issued thereunder. This HRA Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this HRA Plan and the Code, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this HRA Plan shall be deemed superseded to the extent of the conflict.

Section 10.03 Expenses. All reasonable expenses incurred in administering the HRA Plan are currently paid by the Employer.

Section 10.04 Governing Law. This HRA Plan shall be construed, administered and enforced according to the law of the State of Kansas, to the extent not superseded by the Code or any other federal law.

Section 10.05 Headings. The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this HRA Plan or as indicating or controlling the meaning or construction of any provision.

Section 10.06 Indemnification of Employer. If any Participant receives one or more payments or reimbursements under this HRA Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Section 10.07 No Contract of Employment. Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

Section 10.08 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this HRA Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this HRA Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

Section 10.09 Non-Assignability of Rights. The right of any Participant to receive any reimbursement under this HRA Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Section 10.10 HRA Plan Provisions Controlling. In the event that the terms or provisions of any summary or description of this HRA Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this HRA Plan as set forth in this document, the provisions of this HRA Plan shall be controlling.

Section 10.11 Severability. Should any part of this HRA Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the HRA Plan shall be given effect to the maximum extent possible.

*[The remainder of this page is intentionally left blank.]*

**IN WITNESS WHEREOF**, and as conclusive evidence of the adoption of the foregoing instrument comprising the City of Abilene Health Reimbursement Plan, the City of Abilene has caused this HRA Plan to be executed in its name and on its behalf, on this \_\_\_\_ day of \_\_\_\_\_, 2012.

**CITY OF ABILENE, KANSAS**

By: \_\_\_\_\_

Witness  
Signature: \_\_\_\_\_

**HIPAA PRIVACY CERTIFICATION BY THE EMPLOYER  
TO THE HRA PLAN**

I hereby certify on behalf of Plan Sponsor (the "Plan Sponsor") that the HRA Plan has incorporated the provisions required by 45 C.F.R. § 164.504(f)(2)(ii), effective as of March 1, 2012.

I further certify on behalf of the Plan Sponsor that the Plan Sponsor agrees to comply with the provisions of the Plan governing the use and disclosure of PHI or e-PHI by the HRA Plan to the Plan Sponsor. This Certification is made pursuant to 45 C.F.R. § 164.504(f)(2)(ii).

**CITY OF ABILENE**

By: \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX A

The HRA Plan contains the general rules governing what Medical Care Expenses are reimbursable. This Appendix, as referenced in the HRA Plan document, specifies certain expenses that *are not reimbursable*, even if they meet the definition of “medical care” under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

### Exclusions:

*The following expenses are not reimbursable*, even if they meet the definition of “medical care” under Code § 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

- Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee’s, Spouse’s, or Dependent’s inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code § 213(d).
- Over-the-counter drugs or medicines that are purchased without a prescription.

*[The remainder of this page is intentionally left blank.]*

**CITY OF ABILENE**  
**HEALTH REIMBURSEMENT ARRANGEMENT PLAN**

**Summary Plan Description**

**City of Abilene**  
**Health Reimbursement Arrangement Plan**  
**Summary Plan Description**

**Table of Contents**

**Introduction..... 1**

**PART I. General Information About the HRA Plan..... 1**

I-1. What is the purpose of the HRA Plan?..... 1

I-2. When did the HRA Plan take effect? ..... 1

I-3. Who can participate in the HRA Plan?..... 1

I-4. What Benefits are offered through the HRA Plan? ..... 2

I-5. How will the HRA Plan work?..... 2

I-6. Are there any limitations on Benefits available from the HRA Plan?..... 3

I-7. How do I become a Participant?..... 4

I-8. What if I terminate my employment during the Plan Year?..... 4

I-9. What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the HRA Plan?..... 5

I-10. Will I have any administrative costs under the HRA Plan? ..... 5

I-11. How long will the HRA Plan remain in effect? ..... 5

I-12. Are my Benefits taxable? ..... 5

I-13. What happens if my claim for Benefits is denied?..... 6

I-14. Who is the Plan Administrator? ..... 10

**PART II. Administrative Information ..... 10**

**PART III. HIPAA Privacy Rights..... 11**

**PART IV. Definitions ..... 13**

**PART V. Miscellaneous ..... 14**

**City of Abilene**  
**Health Reimbursement Arrangement Plan**  
**Summary Plan Description**

**Introduction**

The City of Abilene (the Employer) offers the City of Abilene Health Reimbursement Arrangement Plan (the “HRA Plan”) for Eligible Employees. Under federal tax law, the HRA Plan is known as a “Health Reimbursement Arrangement.”

This summary plan description (SPD) describes the basic features of the HRA Plan, how it operates, and how you can get the maximum advantage from it. The SPD is only a summary of the key parts of the HRA Plan and a brief description of your rights as a Participant. If there is a conflict between the HRA Plan document and this SPD, the HRA Plan document will control. Definitions of capitalized terms used in this SPD are contained in Part V.

**PART I. General Information About the HRA Plan**

**I-1. What is the purpose of the HRA Plan?**

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own and their covered Spouses’ and Dependents’ Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the HRA Plan generally are excludable from taxable income.

**I-2. When did the HRA Plan take effect?**

The HRA Plan became effective March 1, 2012.

**I-3. Who can participate in the HRA Plan?**

In order to become a Participant, you must satisfy each of the following conditions:

- (a) *Employee.* You are an Employee of the Employer;
- (b) *Regularly Scheduled to Work.* You are regularly scheduled to work twenty (20) or more hours per week; and
- (c) *Participation in Medical Plan.* You participate in one of the options under the Medical Plan other than a “high-deductible health plan” option.

Once you have met the HRA Plan’s eligibility requirements, your coverage will commence on the first day of the month coincident with or next following completion and submission to the Plan Administrator of the Enrollment Form for the Medical Plan.

If you are a Participant, you may also be reimbursed for eligible Medical Care Expenses incurred by your Spouse and Dependents.

#### **I-4. What Benefits are offered through the HRA Plan?**

Once you become a Participant, the HRA Plan will maintain an “HRA Account” in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan (as well as the Employer’s health FSA (if any)), before any Benefits are payable from the HRA Plan.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the HRA Account of each Participant in the HRA Plan.

If you are covered under the HRA Plan on the first day of the Plan Year, the maximum annual amount set forth below will be available to you on March 1<sup>st</sup>. If you were not covered under the HRA Plan on March 1<sup>st</sup> of the current Plan Year (e.g., you were not employed by the Employer, you were not eligible for coverage), your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount (if any) in your HRA Account will not remain available in the next Plan Year.

#### **I-5. How will the HRA Plan work?**

The HRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- (a) You must submit a claim to the Claims Administrator and provide any additional information requested by the Claims Administrator;
- (b) A request for payment must relate to Medical Care Expenses incurred by you, your Spouse, or your Dependent during the time you were a Participant under this HRA Plan; and
- (c) A request for payment must be submitted within ninety (90) days following the close of the Plan Year in which the Medical Care Expense was incurred.

Claims must be submitted in writing. The Claims Administrator may require that Participants submit claims on a form provided by the Claims Administrator. The claim must set forth:

- (a) The individual(s) on whose behalf the Medical Care Expenses were incurred;
- (b) The nature and date of the Medical Care Expenses so incurred;
- (c) The amount of the requested reimbursement; and
- (d) A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that the Claims Administrator may request.

**I-6. Are there any limitations on Benefits available from the HRA Plan?**

Only Medical Care Expenses are covered by the HRA Plan. A Medical Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible Medical Care Expenses are (a) prescription and over-the-counter drugs or medicines purchased pursuant to a prescription; (b) dental expenses; (c) dermatology; (d) physical therapy; and (e) contact lenses or glasses used to correct vision impairment. ***Only Medical Care Expenses incurred in order to meet the deductible under the City of Abilene Medical Plan are eligible for reimbursement.*** Your Employer or the Claims Administrator can provide you with more information about which expenses are eligible for reimbursement.

Some examples of expenses that are not Medical Care Expenses and are not eligible for reimbursement include the following:

- (a) Pregnancy testing kits.
- (b) Health insurance premiums for any other plan (including a plan sponsored by the Employer).
- (c) Long-term care services.
- (d) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- (e) The salary expenses of a nurse to care for a healthy newborn at home.
- (f) Funeral and burial expenses.
- (g) Household and domestic help (even if recommended by a qualified physician due to an employee's, Spouse's, or Dependent's inability to perform physical housework).
- (h) Massage therapy.
- (i) Home or automobile improvements.
- (j) Custodial care.
- (k) Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

- (l) Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- (m) Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- (n) Bottled water.
- (o) Maternity clothes.
- (p) Diaper service or diapers.
- (q) Cosmetics, toiletries, toothpaste, etc.
- (r) Vitamins and food supplements, even if prescribed by a physician.
- (s) Uniforms or special clothing, such as maternity clothing.
- (t) Automobile insurance premiums.
- (u) Transportation expenses of any sort, including transportation expenses to receive medical care.
- (v) Psychotherapy (including psychoanalysis).
- (w) Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- (x) Any item that does not constitute “medical care” as defined under Code § 213.

**I-7. How do I become a Participant?**

If you meet the eligibility requirements described in Section I-3, you are an Eligible Employee and may become a Participant in the HRA Plan on the first day of the calendar month coincident with or next following the date you enroll in the HRA Plan in accordance with procedures established by your Employer.

**I-8. What if I terminate my employment during the Plan Year?**

If you cease to be an Eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA Plan will terminate unless you elect COBRA continuation coverage as described below. You will be reimbursed for any Medical Care Expenses incurred prior to your termination date, up to your account balance in the HRA Account, provided that you comply with the reimbursement request procedures required under the HRA Plan (see Section I-5 for more information on the reimbursement request process).

**I-9. What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the HRA Plan?**

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- (a) Your termination from employment or reduction of hours;
- (b) Your divorce or legal separation from your Spouse;
- (c) Your becoming eligible to receive Medicare benefits; or
- (d) Your Dependent child's ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Plan Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

**I-10. Will I have any administrative costs under the HRA Plan?**

Generally, no. The Employer is currently bearing the entire cost of administering the HRA Plan while you are an Employee.

**I-11. How long will the HRA Plan remain in effect?**

Although the Employer expects to maintain the HRA Plan indefinitely, it has the right to terminate the HRA Plan at any time. The Employer also reserves the right to amend the HRA Plan at any time and in any manner that it deems reasonable, in its sole discretion.

**I-12. Are my Benefits taxable?**

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

### **I-13. What happens if my claim for Benefits is denied?**

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the HRA Plan are discussed below.

#### **(a) *When must I receive a decision on my claim?***

You are entitled to notification of the decision on your claim within 30 days after the Claims Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Administrator. The Claims Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Claims Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Administrator will make the decision based on the information that it has.

#### **(b) *What information will a notice of denial of a claim contain?***

If your claim is denied, the notice that you receive from the Claims Administrator will include the following information:

- (1) Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- (2) The specific reason for the denial;
- (3) A reference to the specific HRA Plan provision(s) on which the denial is based;
- (4) Any denial code (and its corresponding meaning) that was used in denying the claim;
- (5) A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- (6) A description of the HRA Plan's internal and external review procedures and the time limits applicable to such procedures; and
- (7) If the Claims Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

#### **(c) *Do I have the right to appeal a denied claim?***

Yes, you have the right to an internal appeal of the Claims Administrator's denial of your claim, and, if applicable, an external review by an independent review organization ("IRO").

**(d) *Do I have to appeal a denied claim before I go to court?***

You will not be allowed to take legal action against the HRA Plan, the Employer, the Claims Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless you exhaust your *internal* appeal rights. But you do not have to pursue *external* review in order to preserve your right to file a lawsuit. (In fact, as explained later in this SPD, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.)

**(e) *What are the requirements of my internal appeal?***

Your internal appeal must be in writing, must be provided to the Claims Administrator, and must include the following information:

- (1) Your name and address;
- (2) The fact that you are disputing a denial of a claim or the Claims Administrator's act or omission;
- (3) The date of the notice that the Claims Administrator informed you of the denied claim; and
- (4) The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Administrator's act or omission.

You should also include any documentation that you have not already provided to the Claims Administrator.

**(f) *Is there a deadline for filing my internal appeal?***

Yes. Your internal appeal must be delivered to the Claims Administrator within 180 days after receiving the denial notice or the Claims Administrator's act or omission. *If you do not file your internal appeal within this 180-day period, you lose your right to appeal.* Your internal appeal will be heard and decided by the Claims Administrator.

**(g) *How will my internal appeal be reviewed?***

Anytime before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Claims Administrator. The HRA Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Claims Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Claims Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you provided, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Claims Administrator's notice of final internal adverse benefit determination. Similarly, if the Claims Administrator identifies a new or additional reason for denying your claim, said new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to said new or additional reason before the due date for the Claims Administrator's notice of final internal adverse benefit determination.

The internal appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA Plan who is neither the individual who made the original determination nor an individual who is a subordinate of the individual who made the initial determination, nor an individual whose terms and conditions of employment are affected by the results of his/her decision.

If the internal appeal determination will be based on the medical judgment of a health care professional retained by the Claims Administrator, the health care professional retained for purposes of the internal appeal shall not be or be a subordinate to an individual who was consulted in connection with the determination that is being appealed.

**(h) *When will I be notified of the decision on my internal appeal?***

The Claims Administrator must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

**(i) *What information is included in the notice of the denial of my internal appeal?***

If your internal appeal is denied, the notice that you receive from the Claims Administrator will include the following information:

- (1) Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- (2) The specific reason for the denial upon review;
- (3) A reference to the specific HRA Plan provision(s) on which the denial is based;
- (4) Any denial code (and its corresponding meaning) that was used in denying the claim;
- (5) A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits;
- (6) If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request;
- (7) A statement of your right to bring an external appeal or a civil action under ERISA § 502(a).

**(j) *Do I have the right to seek a review of a denied claim to an external third-party?***

You have the right to an external review of the Claims Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA Plan's eligibility requirements.

**(k) *What are the requirements of my external review?***

Within 5 days after receiving your request for external review, the Plan Administrator will determine whether the claim is eligible for review under the external review process. This determination is based on whether:

- (1) You are or were covered under the HRA Plan at the time the claim was made or incurred;
- (2) The denial relates to your failure to meet the HRA Plan's eligibility requirements (if the claim involves an eligibility issue, external review is not available);
- (3) You have exhausted the HRA Plan's internal claims and appeal procedures; and
- (4) You have provided all the information required to process an external review.

Within one (1) business day after completion of this preliminary review, the Plan Administrator will provide written notification to you of whether the claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Plan Administrator will notify you of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the Plan Administrator's notice will describe the information needed to complete it. You will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

If your request is eligible for the external review process, the HRA Plan will assign it to an IRO. The IRO is responsible for notifying you, in writing, that the request for external review has been accepted. The notice will include a statement that you may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the HRA Plan. The HRA Plan may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.

If the HRA Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all the information in the record, as well as additional information where appropriate and available, such as the following:

- (1) Your medical records, or the medical records of your Spouse or your Dependent, as applicable;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by you, the HRA Plan or issuer, or the treating provider;
- (4) The terms of the HRA Plan;
- (5) Appropriate practice guidelines;
- (6) Any applicable clinical review criteria developed and used by the HRA Plan; and
- (7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to you and the HRA Plan of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain the following:

- (1) A general description of the reason for the external review, including information sufficient to identify the claim;
- (2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- (3) References to the evidence or documentation the IRO considered in reaching its decision;
- (4) Discussion of the principal reason(s) for the IRO's decision;
- (5) A statement that the determination is binding (except to the extent other remedies may be available under State or Federal law);
- (6) A statement that judicial review may be available to you; and
- (7) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

In addition, if you reside in a county where 10% or more of the population does not speak English, the notice must be set forth in the applicable non-English language.

**(m) *When will I be notified of the decision on my external appeal?***

The ISO must notify you and the Claims Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The ISO's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

**I-14. Who is the Plan Administrator?**

The Employer is the Plan Administrator and the named fiduciary for the HRA Plan.

**PART II. Administrative Information**

The City of Abilene appoints Freedom Claims to act as the Claims Administrator with respect to claims for benefits under this HRA Plan. Freedom Claims is hereby delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims. The Plan Administrator's failure to enforce any provision of the HRA Plan shall not affect its right to later enforce that provision or any other provision of the HRA Plan. The Plan Administrator may delegate some of its administrative duties to agents.

**Name of HRA Plan: City of Abilene Health Reimbursement Arrangement Plan**

**Plan Sponsoring: City of Abilene, Kansas**

**Plan Administrator: City of Abilene, Kansas**

**Contact Person: Penny Soukup**

**Plan Administrator's Telephone Number: (785) 263-2550**

**Plan Administrator's Employer Identification Number (EIN): 48-6017973**

**Plan Number: 512**

**Plan Year: March 1 through February 28**

**Agent for Service of Process: Service may be made on the Plan Administrator at the address listed above.**

**Type of Plan:** The HRA Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

**Type of Administration:** The Plan Administrator pays applicable Benefits from the general assets of the Employer.

**Funding:** The HRA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

### **PART III. HIPAA Privacy Rights**

#### **Use and Disclosure of Protected Health Information**

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization (see the definition of "Protected Health Information" in Part IV). For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Officer: Penny Soukup Human Resources Director/City Clerk at P.O. Box 519 Abilene, Kansas 67410 or by phone at (785) 263-2550.

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

#### **Permitted Uses and Disclosures**

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for the purposes related to:

- (a) Health care treatment;
- (b) Payment of health care;
- (c) Health care operations; and
- (d) Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Officer.

## Disclosures of the Employer

After the Employer has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administrative functions, and the HRA Plan may not disclose PHI to the Employer for purposes of any employment-related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- (a) Not use or further disclose PHI other than as permitted or required by the Privacy Officer of the HRA Plan document or as required by law;
- (b) Ensure that any agents to whom the Employer provides PHI (or certain Electronic Protected Health Information (e-PHI)) received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- (c) Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- (d) Not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
- (e) Promptly report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI it learns about;
- (f) Make PHI available to you in accordance with the requirements of the Privacy Rule;
- (g) Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- (h) Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- (i) Make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purpose of determining the HRA Plan's compliance with HIPAA; and
- (j) If feasible, return or destroy all PHI received from the HRA Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Employer may only disclose your PHI (or certain e-PHI) to the following Employees and may only do so to the extent that the Employees perform HRA Plan administration functions:

- (a) Privacy Officer;

- (b) Employees in the Employer’s Human Resources Department;
- (c) Employees in the Employer’s Office of General Counsel; and
- (d) Any other class of Employees designated in writing by the Privacy Officer.

If an Employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the Employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Officer immediately.

#### **PART IV. Definitions**

In this SPD, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- (a) *Benefits.* The reimbursement benefits for Medical Care Expenses described in the HRA Plan.
- (b) *City Commissioners.* The City Commission of the Employer, or such other person or Commissioners as may be appointed by the Employer to supervise the administration of the HRA Plan or decide appeals.
- (c) *Claims Administrator.* Freedom Claims.
- (d) *COBRA.* The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- (e) *Code.* The Internal Revenue Code of 1986, as amended.
- (f) *Compensation.* The wages or salary paid to an Employee by the Employer.
- (g) *Dependent.* A dependent is a Participant’s child as defined in Code § 152(f)(1) who has not attained age 26, or a dependent as defined in Code § 105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code § 152 definition that is used to determine your tax dependents, except that an individual’s status as a Dependent is determined without regard to the gross income limitation for a “qualifying relative” and certain other provisions of Code §152. The Code § 105(b) definition also allows dependent children up to age 26 to be covered. The HRA Plan will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.
- (h) *Electronic Protected Health Information or e-PHI.* Has the meaning described in 45 C.F.R. § 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information (such as terms are defined in HIPAA).
- (i) *Eligible Employee.* An Employee who meets the eligibility requirements of the HRA Plan.

- (j) *Employee.* An Employee of the Employer who receives Compensation from the Employer. The term shall not include (1) any individual employed by the Employer at a location outside the United States; (2) an independent contractor; and (3) self-employed individuals.
- (k) *Employer.* The City of Abilene, Kansas.
- (l) *HRA Account.* The recordkeeping account established in your name by the Employer on the basis of which your eligible Medical Care Expenses will be paid or reimbursed.
- (m) *HRA Plan.* The City of Abilene Health Reimbursement Arrangement Plan, as amended or restated from time to time.
- (n) *Medical Care Expenses.* See Section I-6 for a description of Medical Care Expenses.
- (o) *Medical Plan.* The group health plan providing major medical benefits which is sponsored and maintained by the Employer.
- (p) *Participant.* An Eligible Employee who becomes a Participant in the HRA Plan.
- (q) *Plan Administrator.* The Employer.
- (r) *Protected Health Information or PHI.* This generally includes all information, whether written or oral, in connection with the HRA Plan that (1) is created or received by the HRA Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.
- (s) *Plan Year.* The 12-month period ending on February 28.
- (t) *Spouse.* An individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

## **PART V. Miscellaneous**

### **Effect of the HRA Plan on Your Employment Rights**

The HRA Plan is not to be construed as giving you any rights against the HRA Plan except those expressly described in this SPD. The HRA Plan is not a contract of employment between you and the Employer.

### **Prohibition Against Assignment of Benefits**

No Benefits payable at any time under the HRA Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

### **Overpayments or Errors**

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA Plan.

If you do not refund the overpayment or erroneous payment, the HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

\*\*\*\*\*

**CITY OF ABILENE  
HEALTH REIMBURSEMENT ARRANGEMENT PLAN  
ENROLLMENT FORM**

**PART I: EMPLOYEE INFORMATION** *(Please print)*

Employee Name: _____	Social Security Number: _____
Daytime Phone Number: _____	

**PART II: COVERED DEPENDENTS.** *Please enter the name of your spouse and any dependents that you will cover under this plan. Dependent children up to age 26 may be covered under this Plan.*

Name of Covered Individuals	Relationship of Family Member	Date of Birth of Family Member
<i>Example: Jane</i>	<i>Spouse</i>	<i>03-18-67</i>
1.		
2.		
3.		
4.		

**PART III: CERTIFICATION**

I certify that the above listed individuals under Part II are my spouse and/or dependents and are eligible to be covered under the Plan.	
Employee Signature: _____	Date: _____

Please return Enrollment Form to:

**City of Abilene  
P.O. Box 519  
Abilene, Kansas 67410**

For internal use only: Approval: \_\_\_\_\_

**CITY OF ABILENE  
HEALTH REIMBURSEMENT ARRANGEMENT PLAN  
REIMBURSEMENT CLAIMS FORM**

**PART I: EMPLOYEE INFORMATION** *(Please print)*

Employee Name: _____	Employee I.D.: _____
Social Security Number: _____	Daytime Phone Number: _____

**PART II: HEALTH CARE EXPENSES**

Name of Provider	Name & Relationship of Family Member for Whom Service was Provided	Date of Birth of Family Member	Date of Service	Description of Expense*	Documentation** <i>(Please circle the type of documentation attached)</i>	Amount of Out-of-Pocket Expense
<i>Example: Dr. Fisher</i>	<i>Bert / Son</i>	<i>03-18-90</i>	<i>04-11-11</i>	<i>Medical co-payment</i>	<i>Itemized Receipt</i>	<i>\$ 10.00</i>
1.					EOB    Itemized Receipt	\$
2.					EOB    Itemized Receipt	\$
3.					EOB    Itemized Receipt	\$
4.					EOB    Itemized Receipt	\$
<b>TOTAL REIMBURSEMENT</b>						<b>\$</b>

\* Please describe the expense, e.g., medical co-payment, Rx co-payment, co-insurance, etc.

\*\* An "EOB" refers to an "explanation of benefits" which is provided by your carrier; the requirements for an itemized receipt are described below.

**An itemized receipt must document the following information:**

- |                              |                               |                                 |
|------------------------------|-------------------------------|---------------------------------|
| 1. Date of service performed | 3. Service provider's name    | 5. To whom service was provided |
| 2. Type of service received  | 4. Service provider's address | 6. Actual cost to you           |

**Definition of Dependent:**

The Deductible Reimbursement Plan only permits the reimbursement of qualified medical expenses for the participant, spouse and his/her "dependents." Under the Internal Revenue Code, the following individuals may be your "dependents":

1. An adult child under the age of 26.
2. A grandchild, (step-)brother/sister, niece or nephew (a) who lives with you for more than ½ the taxable year, (b) who is under age 19 (or a student under age 24)(or permanently and totally disabled (with no age limit)), and (c) who has not provided over ½ his/her own support.
3. The individuals listed in (2) above plus a grandparent, (step-)mother/father, aunt/uncle, in-law (a) whose gross income is less than the exemption amount in Internal Revenue Code Section 151(d) (beginning in 2009, this is \$3,650 (before phaseout), (b) for whom the taxpayer provides more than ½ the support, and (c) who does not fit the definition in (2) above.

**PART III: CERTIFICATION**

I certify that the expenses on this Claims Form are accurate and true. I further certify that these expenses are for a person covered under the Truck Parts & Equipment, Inc. Medical Plan, the expenses are eligible expenses which have not been previously reimbursed under this or any other benefit plan, and these expenses will not be claimed as an income tax deduction.	
Employee Signature: _____	Date: _____

Please return Claims Form to:

**City of Abilene  
P.O. Box 519  
Abilene, Kansas 67410**

*You should retain a copy of the claim and attachments for your records prior to submitting your claim.*

For internal use only: Approval: \_\_\_\_\_

# **MINUTES / RESOLUTIONS**

RESOLUTION NO. \_\_\_\_\_

**A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT AND ADOPTION OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH PLANS.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the "City") has recommended that the **City of Abilene Cafeteria Plan** be amended by replacement pages, effective April 1, 2004, to provide for the addition of new welfare benefit plans.

**WHEREAS**, the Mayor of the City of Abilene, Kansas has recommended that the following Plans be adopted, effective April 1, 2004:

**City of Abilene Health Flexible Spending Account Plan; and  
City of Abilene Dependent Care Assistance Plan.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas has recommended that the City of Abilene Health Flexible Spending Account be amended in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended, to permit such plan to share "protected health information" with "authorized employees" for "plan administration functions";

**WHEREAS**, the Mayor deems it to be in the best interests of the City to further approve the same;

**NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:**

Section 1. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Cafeteria Plan**, as amended by replacement pages, which is to be effective as of April 1, 2004. The amendments to the **City of Abilene Cafeteria Plan** shall be, and hereby are, adopted, and the amended Articles II, III and IV dated "04/03" shall be substituted for Articles II, III and IV of the current document, a copy of the amended Articles shall be attached to and made a part of this Resolution, and a copy of the Articles being replaced shall be retained as part of the permanent records of the City.

Section 2. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the Plans listed above as adopted, each of which Plans is to be effective as of April 1, 2004.

Section 3. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the HIPAA medical privacy amendments to the City of Abilene Health Flexible Spending Account, which is to be effective as of April 14, 2004. A copy of the Amendments shall be attached to and made a part of this Resolution.

Section 4. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 5. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

RESOLUTION NO. \_\_\_\_\_

**A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH AMENDMENTS.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the "City") has recommended that the **City of Abilene Cafeteria Plan**, the **City of Abilene Medical Plan** and the **City of Abilene Health Flexible Spending Account Plan** be amended by replacement pages, effective March 1, 2005, in order to comply with the final Department of Labor COBRA regulations;

**WHEREAS**, the Mayor deems it to be in the best interests of the City to further approve the same;

**NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:**

Section 1. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Cafeteria Plan** the **City of Abilene Medical Plan** and the **City of Abilene Health Flexible Spending Account Plan**, as amended by replacement pages, which is to be effective as of March 1, 2005. The amendments shall be, and hereby are, adopted, and the existing pages 2.1 and 2.2 of the Cafeteria Plan, existing pages 1 through 4 of the Medical Plan and the existing pages 4.1 and 4.2 of the Health Flexible Spending Account Plan shall be replaced with the new pages 2.1 through 2.3 of the Cafeteria Plan, the new pages 1 through 6 of the Medical Plan and the new pages 4.1 through 4.3 of the Health Flexible Spending Account Plan, a copy of the new pages shall be attached to and made a part of this Resolution, and a copy of the pages being replaced shall be retained as part of the permanent records.

Section 2. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 3. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

**PASSED, APPROVED AND RESOLVED** by the governing body of the City of Abilene, Kansas, this \_\_\_\_\_ day of \_\_\_\_\_, 2005.

CITY OF ABILENE, KANSAS

By: \_\_\_\_\_  
Lynn Peterson, Mayor

[Seal]

ATTEST:

\_\_\_\_\_  
Penny L. Soukup, City Clerk

**RESOLUTION NO. \_\_\_\_\_**

**A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH AMENDMENTS.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the “City”) has recommended that the **City of Abilene Medical Plan** be amended by replacement pages, effective March 1, 2007, in order to provide for a change in the insurance company for the Prescription Drug Coverage.

**WHEREAS**, the Mayor deems it to be in the best interests of the City to further approve the same;

**NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:**

Section 1. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Medical Plan**, as amended by replacement pages, which is to be effective as of March 1, 2007. The amendments shall be, and hereby are, adopted, and the existing pages 5 and 6 of the Medical Plan shall be replaced with the new pages 5 and 6 of the Medical Plan, a copy of the new pages shall be attached to and made a part of this Resolution, and a copy of the pages being replaced shall be retained as part of the permanent records.

Section 2. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 3. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

**PASSED, APPROVED AND RESOLVED** by the governing body of the City of Abilene, Kansas, this \_\_\_\_\_ day of \_\_\_\_\_, 2007.

CITY OF ABILENE, KANSAS

By: \_\_\_\_\_  
Judy Leyerzapf, Mayor

[Seal]

ATTEST:

\_\_\_\_\_  
Penny L. Soukup, City Clerk

RESOLUTION NO. 052609

**A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH AMENDMENTS.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the "City") has recommended that the **City of Abilene Employee Group Vision Plan** be adopted and approved, effective March 1, 2009.

**WHEREAS**, the Mayor deems it to be in the best interests of the City to further approve the same;

**NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:**

Section 1. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Cafeteria Plan**, as amended by replacement pages, which is to be effective as of March 1, 2009. The amendments to the **City of Abilene Cafeteria Plan** shall be, and hereby are, adopted, and the amended pages 2.1 and 2.2 dated "05/09" shall be substituted for pages 2.1 and 2.2 of the current document, a copy of the amended pages shall be attached to and made a part of this Resolution, and a copy of the pages being replaced shall be retained as part of the permanent records of the City.

Section 2. The City Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Employee Group Vision Plan** effective as of March 1, 2009.

Section 3. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 4. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

**PASSED, APPROVED AND RESOLVED** by the governing body of the City of Abilene, Kansas, this 26th day of May, 2009.

CITY OF ABILENE, KANSAS

By: Nesha Bailey-Mason  
Nesha Bailey-Mason, Mayor



ATTEST:  
Penny L. Soukup  
Penny L. Soukup, City Clerk

RESOLUTION NO. 080910-2

**A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH AMENDMENTS.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the "City") has recommended that the amendment to the **City of Abilene Cafeteria Plan**, be amended, effective April 1, 2009, to reflect two new HIPAA special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009.

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the "City") has recommended that the **City of Abilene Employee Prescription Drug Plan**, **City of Abilene Employee Group Medical Plan**, **City of Abilene AFLAC After-Tax Plan** and the **City of Abilene AFLAC Pre-Tax Plan** be amended and restated, effective March 1, 2010.

**WHEREAS**, the Mayor deems it to be in the best interests of the City to further approve the same;  
**NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:**

Section 1. The City Clerk/Human Resource Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Cafeteria Plan**, as amended by replacement pages, which is to be effective as of March 1, 2010. The amendments to the **City of Abilene Cafeteria Plan** shall be, and hereby are, adopted, and the amended pages 2.1-2.3 and 4.3-4.8 dated "07/10" shall be substituted for pages 2.1-2.3 and 4.3-4.7 of the current document; the amendments to the **City of Abilene Health Flexible Spending Account Plan** shall be, and hereby are, adopted, and the amended Articles V-VII dated "07/10" shall be substituted for Articles V-VI of the current document, copies of the amended pages shall be attached to and made a part of this Resolution, and copies of the pages being replaced shall be retained as part of the permanent records of the City.

Section 2. The City Clerk/Human Resource Manager of the City of Abilene, Kansas is authorized and directed to execute and deliver the City of Abilene Employee Prescription Drug Plan, the City of Abilene Employee Group Medical Plan, the City of Abilene AFLAC Pre-Tax Plan, and the City of Abilene AFLAC After-Tax Plan effective as of March 1, 2010.

Section 3. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 4. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

**PASSED, APPROVED AND RESOLVED** by the governing body of the City of Abilene, Kansas, this 9<sup>th</sup> day of August, 2010.



[Seal]

ATTEST

*Penny L. Soukup, CMC*  
Penny L. Soukup, CMC City Clerk

CITY OF ABILENE, KANSAS

By: *Diane Miller*

Diane Miller, Mayor

RESOLUTION NO. 050911-2

A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH AMENDMENTS.

WHEREAS, the Mayor of the City of Abilene, Kansas (the "City") has recommended that the City of Abilene Health Flexible Spending Account Plan, be amended, effective January 1, 2011, to reflect that there is a change in reimbursement for over-the-counter drugs and medicine (other than insulin) pursuant to the Patient Protection and Affordable Care Act of 2010;

WHEREAS, the Mayor deems it to be in the best interests of the City to further approve the same;

NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:

Section 1. The City Clerk of the City of Abilene, Kansas is authorized and directed to execute and deliver the City of Abilene Health Flexible Spending Account Plan, as amended by replacement pages, which is to be effective as of January 1, 2011. The amendments to the City of Abilene Health Flexible Spending Account Plan shall be, and hereby are, adopted, and the amended pages 2.1, 2.2, 5.1 and 5.5 dated "04/11" shall be substituted for pages 2.1, 2.2, 5.1 and 5.5 of the current document, copies of the amended pages shall be attached to and made a part of this Resolution, and copies of the pages being replaced shall be retained as part of the permanent records of the City.

Section 2. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 3. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

PASSED, APPROVED AND RESOLVED by the governing body of the City of Abilene, Kansas, this 9<sup>th</sup> day of May, 2011.



CITY OF ABILENE, KANSAS

By: Lynn Peterson  
Lynn Peterson, Mayor

Penny L. Soukup  
Penny L. Soukup, City Clerk

RESOLUTION NO. \_\_\_\_\_

**A RESOLUTION OF THE CITY OF ABILENE, KANSAS, AUTHORIZING THE AMENDMENT OF CERTAIN WELFARE BENEFIT PLAN DOCUMENTS; AND AUTHORIZING THE EXECUTION OF ALL SUCH DOCUMENTS NECESSARY TO IMPLEMENT SUCH AMENDMENTS.**

**WHEREAS**, the Mayor of the City of Abilene, Kansas (the “City”) has recommended that the **City of Abilene Health Reimbursement Arrangement Plan**, be adopted and approved, effective March 1, 2012.

**WHEREAS**, the Mayor of the City has recommended that the **City of Abilene Employee Group Vision Plan**, be amended, effective March 1, 2012, to reflect the addition of Vision Care Direct as one of the insurance providers for this Employee Group Vision Plan;

**WHEREAS**, the Mayor of the City has recommended that the **City of Abilene Employee Group Medical Plan**, be amended, effective March 1, 2012, to provide for a change in claims administrator for the Medical Plan from Corporate Plan Management to Freedom Claims Management and to reflect the change from being self-funded and administered by Blue Cross Blue Shield to being fully-insured through Preferred Health Systems;

**WHEREAS**, the Mayor of the City has recommended that the **City of Abilene Prescription Drug Plan**, be amended, effective March 1, 2012, to reflect the change in claims administrator from Medtrak Pharmacy Services to Serve You; and

**WHEREAS**, the Mayor deems it to be in the best interests of the City to further approve the same.

**NOW THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF ABILENE, KANSAS:**

Section 1. The City Clerk of the City of Abilene, Kansas is authorized and directed to execute and deliver the **City of Abilene Employee Group Medical Plan**, as amended by replacement pages, which is to be effective as of March 1, 2012. The amendments to the **City of Abilene Employee Group Medical Plan** shall be, and hereby are, adopted, and the amended pages 1.1, 2.4, 3.1, 4.1, 5.1, 6.1, 7.1, and 8.1 dated “04/12” shall be substituted for pages 1.1, 1.2, 2.4, 3.1, 4.1, 5.1-5.6, 6.1, 7.1-7.12, and 8.1 of the current document, the **City of Abilene Employee Group Vision Plan**, as amended by replacement pages, which is to be effective as of March 1, 2012. The amendments to the **City of Abilene Employee Group Vision Plan** shall be, and hereby are, adopted, and the amended pages 2.1, 3.4, 4.1, 6.1, and 7.1 dated “04/12” shall be substituted for pages 2.1, 3.4, 4.1, 6.1, and 7.1 of the current document, the **City of Abilene Prescription Drug Plan**, as amended by replacement pages, which is to be effective as of March 1, 2012. The amendments to the **City of Abilene Prescription Drug Plan** shall be, and hereby are, adopted, and the amended pages 2.4, 3.1, 4.1, 5.1-5.6, 6.1, 7.10, and 8.1 dated “04/12” shall be substituted for pages 2.4, 3.1, 4.1, 5.1-5.6, 6.1, 7.10, and 8.1 of the current document, copies of the amended pages shall be attached to and made a part of this Resolution, and copies of the pages being replaced shall be retained as part of the permanent records of the City.

Section 2. The City Clerk of the City of Abilene, Kansas is authorized and directed to execute and deliver the City of Abilene Health Reimbursement Arrangement Plan effective as of March 1, 2012.

Section 3. The City shall, and the officers, agents and employees of the City are hereby authorized and directed to, take such action and execute such other documents, certificates and instruments as may be necessary or desirable to carry out and comply with the provisions of this Resolution.

Section 4. This Resolution shall take effect and be in full force from and after its approval by the governing body of the City.

**PASSED, APPROVED AND RESOLVED,** by the governing body of the City of Abilene, Kansas, this \_\_\_\_\_ day of \_\_\_\_\_, 2012.

CITY OF ABILENE, KANSAS

By: \_\_\_\_\_  
Lynn Peterson, Mayor

[Seal]

ATTEST:

\_\_\_\_\_  
Penny L. Soukup, City Clerk

# **BENEFIT ELECTION FORMS**

**CITY OF ABILENE, KANSAS**  
**WELFARE BENEFIT PLANS**  
**BENEFIT ELECTION AND SALARY REDUCTION FORM**

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Benefit Election – Select One of the Options Below**

\_\_\_\_\_ I want to receive the benefits available through the City of Abilene Cafeteria Plan. By signing below, I authorize City of Abilene to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries:

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Coverage   | <input type="checkbox"/> Personal Intensive Care Plan |
| <input type="checkbox"/> Personal Accident Plan   | <input type="checkbox"/> Personal Recovery Plus Plan  |
| <input type="checkbox"/> Health FSA - \$_____ / year (\$3,000 maximum)  | <input type="checkbox"/> Cancer Insurance Plan        |
| <input type="checkbox"/> Dependent Care Account - \$_____ / year (\$5,000 maximum; \$2,500 if married but filing a separate return) |   |
| <input type="checkbox"/> Vision Coverage (VSP)  | <input type="checkbox"/> Prescription Drug Coverage   |
| <input type="checkbox"/> Vision Coverage (Vision Care Direct)   |   |

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

\_\_\_\_\_ I decline to participate in the City of Abilene Cafeteria Plan. I understand that, as a result of this decision, I will not receive any of the benefits available through the Cafeteria Plan.

**Important Information**

- (1) By signing below, you are making a binding election concerning your benefits. You may not change your election until the next enrollment period unless you experience a qualifying “election change event” as defined in the provisions of the City of Abilene Cafeteria Plan.
- (2) A special rule applies to the dollar amounts elected for the Health FSA. If you experience a qualifying “election change event” in the middle of a plan year, you may cease your participation in the Health FSA or, if you are not already participating, you may begin to participate. You may not, however, change the dollar amount of your election from one dollar amount to another dollar amount in the middle of a plan year.
- (3) Your election will not remain in effect for subsequent plan years. You must complete a new salary reduction form for each plan year. The dollar amounts elected for the Health FSA and Dependent Care Amount will automatically be reset to zero for subsequent plan years unless you make a new election for a subsequent plan year.
- (4) The dollar amounts, if any, remaining in your Health FSA and/or Dependent Care Account at the end of the plan year will be forfeited, as required by IRS regulations. This is commonly referred to as a “use it or lose it” rule.
- (5) By choosing to receive the benefits available through the City of Abilene Cafeteria Plan, you are authorizing the City of Abilene to reduce your salary by the amount necessary to pay your share of the cost for those benefits. By doing this you will reduce your taxable compensation. As a result, depending on your compensation level, you may pay less Social Security tax and this may have some effect on the amount of your Social Security retirement benefits.

**The above information is a summary of the provisions of the City of Abilene Cafeteria Plan. In the event of a conflict between this summary and the provisions of the Cafeteria Plan, the provisions of the Plan will control.**

**I have read and understand the above information. I have chosen the Benefit Election that is marked on this form.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CITY OF ABILENE CAFETERIA PLAN  
REQUEST TO CHANGE PRE-TAX ELECTIONS**

---

**Employee Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**INSTRUCTIONS.** *Please read the following instructions carefully.*

In order to change your election(s) under the City of Abilene Employee Group Cafeteria Plan, you must do the following:

- (1) Fill out and return a new Benefit Election and Salary Reduction Agreement
- (2) Tell us why you would like to make a new election or change your current election(s) (using this form)
- (3) Tell us when the event that may allow you to change your election took place (or will take place) (using this form)

After you have provided us with the above information, we will review your request. In determining whether we should accept or deny your request, we must follow IRS rules and the rules set forth in the City of Abilene Employee Group Cafeteria Plan. This means, among other requirements, that your request to change your election(s) must be consistent with and on account of the “event(s)” that you have marked below. ***In addition, you must submit your request within 30 days from the date of the event(s) (or 60 days if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP).***

If your request to change your election(s) is approved, it will become effective as follows:

- (1) **HIPAA Special Enrollment for New Dependent.** If your request relates to enrolling a dependent that you have acquired by birth or adoption in the City of Abilene Employee Group Medical Plan, your request will take effect on the date of birth or adoption, even if you submit your request *after* the event (provided you do so within 30 days from the date of the event).

***Example.*** You give birth to a child on March 24<sup>th</sup>. You submit the appropriate paperwork on April 15<sup>th</sup> to add your newborn to coverage under the City of Abilene Employee Group Medical Plan. Your new election will be effective retroactively as of March 24<sup>th</sup>.

- (2) **All Other Changes.** If your request relates to any other type of event, your request will not take effect until the first day of the month coincident with or next following the event, assuming you have completed this form and the Benefit Election and Salary Reduction Agreement. If you timely turn in your forms after the event and after the first business day of the month, your election will not take effect until the first day of the next month.

***Example.*** You are married on January 15<sup>th</sup>. You submit the appropriate paperwork on January 20<sup>th</sup> to add your spouse to coverage. The change will take effect February 1. If, on the other hand, you do not submit the completed paperwork until February 5<sup>th</sup>, your new election will not take effect until March 1<sup>st</sup>.

**REASON YOU WOULD LIKE TO MAKE A CHANGE**

**HIPAA SPECIAL ENROLLMENT EVENT: (Applies only to medical and dental benefits)**

If any of the following events occur, you may change your election under the medical and/or dental benefits in order to add coverage for yourself, your spouse, and/or your dependents. These are known as “HIPAA special enrollment rights.” Please check the appropriate box below if you have experienced a HIPAA special enrollment event and you would like to change your coverage (including changing a coverage option) under the medical and/or dental benefits:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Loss of coverage under another group health plan  | <input type="checkbox"/> New spouse through marriage | <input type="checkbox"/> New dependent through birth or adoption |
| <input type="checkbox"/> Loss of eligibility for Medicaid or a State’s children’s health insurance program (SCHIP) |  |  |
| <input type="checkbox"/> Become eligible for a State premium assistance subsidy from either Medicaid or SCHIP      |  |  |

**(1) CHANGE IN YOUR MARITAL STATUS**

- Marriage
- Divorce, legal separation, or annulment (*must provide documentation*)
- Death of spouse

**(2) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)**

- Birth or adoption of a child (*must provide documentation of adoption*)
- Change in "dependent" status (e.g., age, marriage, obtain full-time employment, no longer lives with you)
- Death of dependent

**(3) CHANGE IN EMPLOYMENT STATUS (*if it affects benefits eligibility*)**

	<u>You</u>	<u>Spouse/Dependent</u>
<input type="checkbox"/> Change from part-time without benefits to part-time with benefits or full-time .....	_____	_____
<input type="checkbox"/> Change from full-time or part-time with benefits to part-time without benefits .....	_____	_____
<input type="checkbox"/> Beginning of Family and Medical Leave ("FMLA") .....	_____	N/A
<input type="checkbox"/> Return from Family and Medical Leave ("FMLA") .....	_____	N/A
<input type="checkbox"/> Beginning of an unpaid leave of absence .....	_____	_____
<input type="checkbox"/> Returning from unpaid leave of absence .....	_____	_____
<input type="checkbox"/> Change in worksite .....	_____	_____
<input type="checkbox"/> Salaried to hourly pay .....	_____	_____
<input type="checkbox"/> Hourly to salaried pay .....	_____	_____
<input type="checkbox"/> Termination of employment .....	_____	_____
<input type="checkbox"/> Beginning of employment .....	_____	_____

Name of dependent: \_\_\_\_\_

**(4) CHANGE IN COVERAGE (DOES NOT APPLY TO HEALTH FSA)**

- Addition or significant improvement of a benefit package option
- Change in coverage under "another employer plan" (Employer, here, means my spouse's or dependent's employer, *or*, another of my employer's plans, if applicable) *and* that other plan permits a change for a reason that can be found on this form
- Open enrollment under "another employer plan" (Employer, here, means my spouse's or dependent's employer, *or*, another of my employer's plans) *and* my plan allows me to make an election for a period of coverage that is different from the period of coverage under the other plan
- Significant reduction in coverage, but *coverage is not lost*
  - Significant increase in the deductible
  - Significant increase in the co-pay
  - Significant increase in the out-of-pocket cost sharing limit
  - Other reduction, constituting an *overall* reduction in coverage (specify): \_\_\_\_\_
- Significant reduction in coverage *resulting in a complete loss of coverage*
  - Elimination of a benefit option
  - HMO ceasing to be available in the area where I reside
  - Overall lifetime or annual limitation
  - Substantial decrease in the medical care providers available under the option
  - Reduction in the benefits for a specific type of medical condition or treatment with respect to which: \_\_\_ I am, \_\_\_ my spouse is, \_\_\_ a dependent is (Name: \_\_\_\_\_) currently in a course of treatment.
  - Other reason that has resulted in a fundamental loss of coverage (specify): \_\_\_\_\_
- Loss of coverage under any group health coverage sponsored by a governmental or educational institution, such as one of the following (*please check*):
  - State Children's Health Insurance Program ("SCHIP")
  - A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization
  - A State health benefits risk pool
  - A Foreign government group health plan
  - Other: \_\_\_\_\_

**(5) CHANGE IN COST OF COVERAGE (DOES NOT APPLY TO HEALTH FSA)**

- Significant *increase* in the cost of my benefit package option
- Significant *decrease* in the cost of my benefit package option

**(6) DEPENDENT CARE ASSISTANCE PLAN (“DCAP”)**

- Adding a daycare provider or changing daycare providers
- Change in hours of dependent care
- Coverage under spouse’s or dependent’s DCAP decreases or ceases
- Dependent’s enrollment in school has decreased the necessary hours for daycare for (*name*): \_\_\_\_\_
- Significant *increase* in the cost of the dependent care provider (except no change can be made where the cost change is imposed by a dependent care provider who is a relative)
- Significant *decrease* in the cost of the dependent care provider (such that you want to make an election)

**(7) OTHER (DOES NOT APPLY TO DCAP ELECTION)**

- Change in residence
- Issuance of Judgment, Decree, or Order (relating to medical or dental coverage)
- Entitlement to Medicare or Medicaid is \_\_\_ lost \_\_\_ gained.

**DATE OF EVENT**

Please provide the date for each event that you marked above:

Event: \_\_\_\_\_ Date of Event: \_\_\_\_\_

Event: \_\_\_\_\_ Date of Event: \_\_\_\_\_

By signing below, I understand and agree to the following:

- An election change may be made only if it is permitted under the terms of the Cafeteria Plan and under the terms of Section 125 of the Internal Revenue Code.
- The Plan Administrator may require me to provide appropriate documentation for any event(s) I have marked.
- The Plan Administrator must review and approve any change before it is given effect. The Plan Administrator, in his or her sole discretion, will make election change determinations.
- ***I have 30 days from the date of the event to turn in my forms; provided, however, that I have 60 days to turn in my forms if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP (see box on page 1).*** If the Plan Administrator determines that I have a valid election change event and the requested change is on account of and consistent with the event, my new election will take effect the first day of the month coincident with or next following the later of the date of the event or the date of the submission of my completed Request to Change Pre-Tax Elections form and Benefit Election and Salary Reduction Agreement. If, however, the event is the birth or adoption of my child, retroactive enrollment in the medical and dental benefits is permitted.

Note: In certain instances, such as the loss of dependent eligibility status, enrollment in certain benefits ends immediately, thereby requiring retroactive termination of coverage. Your dollar election, however, may only be changed prospectively. Thus, if you can anticipate the occurrence of a valid election change event (e.g., the birthday of a dependent, the upcoming hire date of a dependent for a full-time job), then you should submit your completed this form and the Benefit Election and Salary Reduction Agreement prior to the date your salary will be reduced to pay for such coverage.

- The statements I have made on this form, including the boxes I have checked, are true and accurate.

\_\_\_\_\_  
(Participant's Signature)

\_\_\_\_\_  
(Date Submitted)



# INITIAL NOTICE OF COBRA RIGHTS

## INTRODUCTION

You are receiving this Initial Notice of COBRA Rights (the “Notice”) because you have recently become covered under the **City of Abilene Employee Group Medical Plan**, the **City of Abilene Health Flexible Spending Account Plan**, **City of Abilene Employee Group Vision Plan**, **City of Abilene Health Reimbursement Arrangement Plan**, and/or the **City of Abilene Prescription Drug Plan** (collectively known hereinafter as the “Plan”). This Notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end.

**This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This Notice gives only a summary of your COBRA continuation coverage rights. The Plan provides no greater COBRA rights than what COBRA requires – and nothing in this Notice is intended to expand your rights beyond COBRA’s requirements. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description *or* contact the Plan Administrator.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

The name, address and telephone number of the Plan Administrator are as follows:

**City of Abilene  
P.O. Box 519  
Abilene, Kansas 67410  
(785) 263-2550**

The Plan Administrator has the responsibility for administering COBRA continuation coverage, but may have contracted with a third-party administrator to carry out the day-to-day COBRA administrative functions on behalf of the Employer. The party responsible for administering day-to-day COBRA administrative functions, or that party’s address and telephone number, may change from time to time. You should consult the Plan Administrator or Summary Plan Description for the most current address if the COBRA administrator changes.

## COBRA CONTINUATION COVERAGE

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of an event known as a “qualifying event.” Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA coverage must be offered to each person who is a “qualified beneficiary.” You, your covered spouse, and your covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.<sup>1</sup> Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the cost of COBRA coverage.

---

<sup>1</sup> Certain newborns, newly-adopted children and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.

*Employee.* If you are an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because either one of the following qualifying events takes place:

- (1) Your hours of employment are reduced so that you are no longer eligible for coverage; or
- (2) Your employment ends for any reason other than your gross misconduct.

*Spouse.* If you are the spouse of an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because any one of the following qualifying events takes place:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced so that you are no longer eligible for coverage;
- (3) Your spouse's employment ends for any reason other than for gross misconduct;
- (4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.<sup>2</sup>

*Dependent Child.* Your dependent children will become qualified beneficiaries *if* they will lose coverage under the Plan because any one of the following qualifying events takes place:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced so that you are no longer eligible for coverage;
- (3) The parent-employee's employment ends for any reason other than for gross misconduct;
- (4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child no longer satisfies the definition of a "dependent child" under the Plan.

Filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

---

<sup>2</sup> If your spouse cancels coverage for you in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you lost coverage earlier. You must notify the administrator within 60 days after the divorce or legal separation and establish that your ex-spouse, the employee, canceled the coverage earlier in anticipation of the divorce or legal separation in order for COBRA coverage to be made available for the period after the divorce or legal separation.

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all the qualified beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. A qualified beneficiary's COBRA coverage will terminate automatically, however, if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**- IMPORTANT -**

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the first of the month following the date of the qualifying event.

When the qualifying event is the end of employment, a reduction in hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

**For all other qualifying events – that is, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child – you must notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.**

**You must follow the Plan's reasonable procedures for providing notice which are found in your summary plan description. If these procedures are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.**

**MAXIMUM PERIOD OF COVERAGE UNDER THE PLAN**

The duration of the maximum period of COBRA coverage will vary depending on (1) the qualifying event and (2) whether or not there is a second qualifying event or a disability extension. The following are COBRA qualifying events if they are coupled with a loss of coverage under the Plan. The maximum period of coverage permitted under COBRA is listed along with each event:

- (1) **Death of the employee** – COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
- (2) **Employee becomes entitled to Medicare (under Part A, Part B, or both) –**
  - (A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

- (B) See the examples under qualifying events (5) and (6) below for how an employee's entitlement to Medicare may affect the spouse's or dependent child's maximum coverage period when coverage has been lost due to the employee's termination of employment or reduction in hours.
- (3) **Divorce or legal separation –**
- (A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.
  - (B) *Example.* A covered employee and his spouse divorce. If the Plan Administrator is timely and appropriately notified of the divorce, the spouse, who would otherwise lose coverage, may elect COBRA coverage if it is elected within 60 days after the later of the divorce or the loss of coverage in accordance with the Plan's reasonable procedures for providing notice. Any dependent child, who was also covered at the time of the divorce and who will otherwise lose coverage due to the divorce, may also elect COBRA coverage.
- (4) **Dependent child losing eligibility as a dependent child –**
- (A) COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.
  - (B) *Example.* A dependent child is covered under the Plan. The dependent child turns age 26. As a result, the dependent child will "age-out" of the Plan and lose coverage at the end of the month. Following the Plan's reasonable procedures for providing notice as found in the summary plan description, however, COBRA coverage is timely elected and the individual is given 36 months of continuation coverage.
- (5) **Termination of employment –**
- (A) COBRA continuation coverage may last for up to 18 months for the former employee, the spouse and any dependents who are qualified beneficiaries.
  - (B) The 18-month period for the spouse and/or dependent child may be extended if there is a "second qualifying event." See (7) below.
  - (C) If the employee became entitled to Medicare benefits less than 18 months before his or her termination of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.
    - (i) *Example.* A covered employee became entitled to Medicare eight (8) months before the date on which his employment terminated. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of his termination (36 months minus 8 months).

(6) **A reduction in the employee's hours of employment, causing the employee to lose eligibility for coverage –**

- (A) COBRA coverage may last for up to 18 months for the employee, spouse and any dependents who are qualified beneficiaries.
- (B) The 18-month period may be extended if there is a “second qualifying event.” See (7) below.
- (C) If the employee became entitled to Medicare benefits less than 18 months before coverage is lost due to a reduction in hours of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.
  - (i) *Example.* A covered employee became entitled to Medicare eight (8) months before the date on which he stopped being eligible for coverage due to a drop in the number of hours employed. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of the reduction in hours (36 months minus 8 months).

(7) **Second Qualifying Event –**

- (A) If the employee's family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described below), the spouse and dependent children (along with certain newborns and newly adopted children) can get up to 18 additional months of COBRA coverage, for a maximum of 36 months. In order for this to occur, the following requirements must be met:
  - (i) The spouse and dependent children must be qualified beneficiaries who have elected and paid for COBRA coverage.
  - (ii) COBRA coverage is still in effect for the qualified beneficiaries at the time of the second qualifying event.
  - (iii) The event is one that would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
  - (iv) The Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow its reasonable procedures for providing notice as found in the summary plan description.
- (B) **If the notice procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.**

(8) **Disability Extension –**

- (A) COBRA coverage may be extended from 18 months to 29 months.
- (B) If the covered employee or anyone in his/her family covered under the Plan is determined by the Social Security Administration to be disabled and the Plan Administrator is notified in a timely fashion, the covered employee and his/her entire family (along with certain newborns and newly adopted children) may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.
- (C) In order to receive the disability extension, each individual must be a qualified beneficiary who has elected and is paying for COBRA coverage and whose COBRA coverage is still in effect at the time of the disability determination.
- (D) The disability must have started some time before the 61<sup>st</sup> day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage.
- (E) The Plan Administrator must be notified in writing of the Social Security Administration's determination within 60 days after the latest of (a) the date of the determination, (b) the date of the covered employee's termination or reduction of hours, and (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, notice must be given before the end of the 18-month period of COBRA coverage.
- (F) You must follow the Plan's procedures providing notice. **If these procedures are not followed or if notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.**

**SPECIAL RULES FOR HEALTH FSA**

COBRA coverage under a health flexible spending account ("Health FSA") maintained by the Employer will only be offered to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if he or she has been reimbursed for an amount that is less than his or her contributions through the time of the qualifying event. In addition, the use-it-or-lose-it rule will continue to apply, so any unused amount will be forfeited at the end of the plan year. Finally, COBRA coverage will end on the *last day of the plan year* in which the qualifying event occurred, regardless of the qualifying event.

Each beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

### **Children Born to or Placed for Adoption with the Covered Employee during COBRA Period**

A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (e.g., regarding age).

### **Alternate Recipients under QMCSOs**

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

### **If You Have Questions**

Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator's address as indicated on the first page of this Notice.

### **Keep your Plan Informed of Address Changes**

**In order to protect your family's rights, you should keep the Plan Administrator informed of any change in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

# **CHECKLISTS**

## **CHECKLIST OF DOCUMENTS TO BE DISTRIBUTED TO PARTICIPANTS UPON BECOMING ELIGIBLE TO PARTICIPATE IN ONE OR MORE PLANS**

The following documents should be given to participants at the time they become eligible to participate in one or more of the plans:

### **1) Summary Plan Descriptions for the Cafeteria, AFLAC After-Tax, and Health Reimbursement Arrangement Plans**

*These are summaries of the main provisions of the Cafeteria, AFLAC After-Tax, and Health Reimbursement Arrangement Plans. It is recommended that the SPDs be distributed to new participants immediately, although, technically, you have 90 days from the participant's date of entry to distribute the SPD.*

### **2) Pre-Tax Benefit Election and Salary Reduction Agreement**

*This form is used by the participant to elect which benefits under the Cafeteria Plan the participant would like to participate in and have his or her compensation reduced in order to pay for his or her share of the cost of such benefits on a pre-tax basis. In addition, the form allows the participant to specify how much of his or her salary he or she would like to contribute to the health flexible spending account and/or the dependent care assistance plan. The form also authorizes the company to reduce the participant's compensation and it explains how often the participant can revoke or change the election.*

*The participant should complete and return this form to the Plan Administrator.*

### **3) After-Tax Benefit Election and Salary Reduction Agreement**

*This form is used by the participant to elect which benefits the participant would like to participate in and have money deducted from his or her compensation in order to pay for such benefits on an after-tax basis. It also authorizes the company to make such deductions and explains how often the participant can revoke or change the election.*

*The participant should complete and return this form to the Plan Administrator.*

### **4) Initial COBRA Notice**

*Federal law requires that a notice explaining COBRA rights be given to all covered employees and their spouses participating in group health plans. It is recommended that you send the Initial COBRA Notice via first class mail addressed to the covered employee and the covered employee's spouse (if the spouse is also covered under the Plan). For example, if Jane Smith is your employee, both she and her husband John*

*Smith are covered under your plan, and they are both living at the same address, an Initial COBRA Notice should be mailed to either “Mr. and Mrs. John Smith” or to “John and Jane Smith.” This should be done as soon as possible so that they are aware of their obligations to notify the plan administrator if certain events take place, such as a divorce or legal separation. Separate mailings should be made if the employee and spouse live at different addresses. If you give the Notice to an employee at the workplace, you should mail a separate copy to the employee's spouse.*

**5) HIPAA Privacy Notice**

*A HIPAA Privacy Notice must be given to the participant if he or she is enrolled in the health flexible spending account, health reimbursement arrangement, and/or the prescription drug plan. This notice informs the participant how his or her “protected health information” may be used or disclosed and it explains his or her individual rights with regard to “protected health information.”*

**6) Other**

*Any other forms required by the insurance company for an insured plan.*

## **CHECKLIST OF DOCUMENTS TO BE DISTRIBUTED TO PARTICIPANTS UPON TERMINATION OF PARTICIPATION IN ONE OR MORE PLANS**

### **COBRA**

A COBRA Election Notice should be given to participants at the time they terminate participation in the Medical Plan, the Vision Plan, the Prescription Drug Plan, the Health Reimbursement Arrangement, or the Health Flexible Spending Account\* if participation is terminated due to one of the following COBRA triggering events:

- (1) Termination of employment
- (2) Reduction in hours (but only if it results in a loss of eligibility)
- (3) Divorce
- (4) Loss of dependent status
- (5) Entitlement to Medicare
- (6) Death of the Employee-Participant
- (7) Bankruptcy of the Employer

It is recommended that you send the COBRA Election Notice via first class mail to all participants who have lost coverage. A single notice may be sent to an employee, his or her spouse, and any dependent-children that were covered if they are all living at the same address. If, however, the COBRA qualifying event is the loss of dependent status, we recommend mailing separate notices to the covered employee (or spouse) and the dependent who is losing coverage even if they live at the same address. Separate mailings should be made if the employee, spouse, and/or dependents live at different addresses.

If a Participant decides to continue coverage, the Participant should also refer to his or her table of COBRA procedures, which is an appendix to the SPD, to determine what qualifies as a “second qualifying event” after termination of employment or a reduction in hours. Participants may be allowed to extend the maximum length of their COBRA period if the procedures are correctly and timely followed. If a Participant has misplaced his or her COBRA procedures, you should provide them with another copy at this time.

### **HIPAA**

A HIPAA certificate of creditable coverage should be provided to participants at the time they terminate participation in the Medical Plan. You should determine whether or not the insurer or third party administrator, as applicable, will provide this for you.

### **OTHER**

Any other forms required by the insurance company for an insured plan.

\*Only participants with money left in their Health FSA should receive an election notice.