CITY OF SPRINGFIELD

SUMMARY PLAN DESCRIPTION
Health Reimbursement Arrangement

Effective: 1/1/2019

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SUMMARY PLAN DESCRIPTION
HEALTH REIMBURSEMENT ARRANGEMENT

I. Introduction

This Summary Plan Description (SPD) provides, in general terms, the main features of the CITY OF SPRINGFIELD Health Reimbursement Arrangement (the "Plan"), how it can work for you, and how it can benefit you. Definitions of all capitalized terms used in this SPD are contained in Section XIII.

The purpose of the Health Reimbursement Arrangement (HRA) is to reimburse Eligible Employees, up to certain limits, for their own Health Care Expenses. Reimbursements for Health Care Expenses paid by the HRA generally are excludable from taxable income.

You should read this Summary Plan Description carefully so that you understand the provisions of the HRA Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the HRA Plan while you are a Participant. You should direct any questions you have to your Employer. A copy of your HRA Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. **IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL TAKE PRECEDENCE.**

The provisions of the HRA Plan, as initially adopted or subsequently amended and restated, as the case may be, are effective 1/1/2019, through 12/31/2019. Your HRA Plan's financial records are maintained on a fiscal period known as the Plan Year.

II. Administrative Information

The Employer is the Plan Administrator for the HRA Plan in accordance with ERISA § 3(16)(A). The HRA Plan is intended to qualify as an Employer-provided Health Care 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. The Employer'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.

Agent for Service of Process: Service may only be made on the Employer at its principal place of business, or upon its Registered Agent, as reflected in the records of the Secretary of State.

The Employer has retained PacificSource Administrators, Inc. (PSA) to act as the Third Party Administrator and provide certain administrative services associated with the HRA. PSA is not a fiduciary of the HRA Plan. PSA has **no** discretionary authority to interpret HRA Plan provisions or issues arising under the HRA Plan, such as issues of eligibility, coverage, and benefits. PSA is not an "administrator" as defined in ERISA § 3(16)(a).

Nothing herein will be construed to require the Employer or PSA to maintain any fund or to segregate any amount for the benefit of any 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. 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. PSA does not finance or insure the HRA Plan. While the Employer has complete responsibility for the payment of benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

III. Your Plan at a Glance

PERIOD OF COVERAGE and **PLAN YEAR** of this Plan: 1/1/2019 through 12/31/2019

HRA Plan Name:	CITY OF SPRINGFIELD
Three Digit Plan Number:	
Employer Information:	CITY OF SPRINGFIELD 225 FIFTH STREET SPRINGFIELD, OR 97477 (541) 726-2242
Type of Legal Entity:	Govt Entity
Benefits Coordinator:	Human Resources/Benefits Representative
Legal Representative:	CITY OF SPRINGFIELD
Plan Administrator:	CITY OF SPRINGFIELD
Third Party Administrator:	PacificSource Administrators, Inc. PO Box 70168 Springfield, OR 97475 Phone: (800) 422-7038 FAX: (866) 446-6090
Secure Web Portal (TPA):	https://hrbenefitsdirect.com/PSA/SignIn.aspx
Claim Mailing Address (TPA):	PacificSource Administrators, Inc. P.O. Box 2797, Portland, OR 97208
Employer Representative or Named Fiduciary:	CITY OF SPRINGFIELD
The HIPAA Effective date:	1/1/2019
HIPAA Privacy Officer:	CITY OF SPRINGFIELD
PacificSource Administrators Group ID:	PPDB0316

Plan Expenses are paid completely by the Employer while the Employee is an active Participant in the HRA Plan. When Spend Down is allowed, fees may be deducted from any remaining balance.

Your Employer offers a(n) **"Comprehensive A**" Health Reimbursement Arrangement. This HRA Plan is defined as covering all unreimbursed medically necessary health expenses which reimburses all expenses as outlined in IRS Code 213, including long-term care and COBRA premiums.

Reimbursement for prescriptions are: Limited to IRS Code 213 eligible expenses

You will be reimbursed up to the Maximum Account balances for covered Health Care Expenses incurred by you and/or your covered dependents in a Plan Year, if those expenses are not reimbursed under your Employer's major medical or other health insurance plan. Only expenses incurred on or after your entry date and prior to the end of the Plan Year are eligible for payment. An expense is incurred on the date a service is provided or rendered and not on the date that the service is billed or paid.

Annual Credit Amount Your HRA account can only be funded with Employer contributions. Different amounts may be credited for different classes of active Participants**:**

- $900 Tier 1
- $1,200 Tier 2
- $1,800 Tier 3
- $2,400 Tier 4

Carryover of unused funds from prior Plan Year balance allowed: Yes

Carryover of Account Balance of unused funds If carryover is allowed, unused amounts in an Active Participant's HRA will remain available to reimburse eligible expenses incurred in later years**:**

- 100% Tier 1
- 100% Tier 2
- 100% Tier 3
- 100% Tier 4

Maximum Account Balance You will only be reimbursed for covered expenses up to the Maximum Account Balance**:**

- $900 plus any balance carried forward from preceding year Tier 1
- $1,200 plus any balance carried forward from preceding year Tier 2
- $1,800 plus any balance carried forward from preceding year Tier 3
- $2,400 plus any balance carried forward from preceding year Tier 4

Threshold Amount The HRA Plan will reimburse after you have incurred covered expenses. The amount you must pay before the HRA will reimburse is:

- $0 Tier 1
- $0 Tier 2
- $0 Tier 3
- $0 Tier 4

Plan Contribution Frequency: The Annual Credit Amount stated above will be credited to your

account on an Annual basis - funded at the start of the Plan Year.

Expenses are Eligible for: Employee + dependents

Reimbursement Rate: 100% of eligible expenses

Prior year expenses allowed (Does the Plan allow expenses incurred in a prior year to be reimbursed?): Yes

Plan Contributions for Mid-Year Hires are: pro-rated monthly contribution

Plan Contributions for Mid-Year Terminations are: pro-rated value based on the eligibility period

Debit Card Availability on HRA? Yes

Eligibility Requirements: Employees and/or their spouse or dependents must be enrolled in this Employer's group sponsored medical plan or the group sponsored medical insurance plan of a different Employer to be reimbursed for medical care expenses under the HRA Plan.

- Minimum of 20 hours required during each week

Entry Dates:

- First of the month following or coinciding with date of hire

Exclusions:

- Employees on the Non-HIP plan (PPO plan)

Treatment of Rehires:

- If you terminate and are rehired within 1 month, you will immediately rejoin the Plan and be reinstated with the same HRA account balance that the individual had before termination. If you terminate and are rehired 1 month or more after the date of termination you will be treated as a new hire and must re-satisfy (complete the waiting period) the Plan eligibility requirements. Services incurred during the period of termination will not be eligible for reimbursement.

Treatment of Participants that regain eligibility:

- If you experience a loss of eligibility and then later regain eligibility within 1 month, you will immediately rejoin the Plan and be reinstated with the same HRA account balance that the individual had before termination. If you regain eligibility 1 month or more after the loss of eligibility date you will be treated as a new hire and must re-satisfy (complete the waiting period) the Plan eligibility requirements. Services incurred during the period of termination will not be eligible for reimbursement.

Enrollment Process: Your Employer will provide the necessary enrollment materials as applicable.

Benefit Changes: A qualified change in status may allow your Employer to make a mid-plan year change or revocation to your annual credit maximum amount. The Employer, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a change in status.

Claim Reimbursement Forms may be submitted the following ways:

- Electronically via our secure web portal: https://hrbenefitsdirect.com/PSA/signIn.aspx
- Faxed to (866) 446-6090
- Mailed to PO Box 2797, Portland, OR 97208

Claims Submission Period Ends: 90 days after the close of the Plan Year for funds not carried over.

Documentation needed for claim submission:

- Your claim for reimbursement must include a statement from the service provider that you have incurred the expense and the amount of your expense. Note: a statement from the provider may be required to show that an expense is medically necessary

Appeals You may appeal a claim denial by submitting a Request for Review (or other written appeal request) to your Employer's Plan Representative within 180 days of the date of notice of your claim denial.

Cafeteria Plan Coordination:

- In the event that an expense is eligible for reimbursement under both the HRA and a Health FSA the Health FSA pays out first and the HRA pays out last when the Participant's medical care expenses are covered by both the HRA and the Health FSA.

Reimbursement after Termination of Employment:

- Spend down allowed until funds are exhausted. Admin fees will be deducted from the remaining balance.

Reimbursement after Loss of Eligibility (still employed):

- Spend down allowed until termination of employment. Admin fees will be deducted from the remaining balance.

COBRA continuation coverage: Per Federal Law, COBRA continuation coverage may be offered. **Note:** *COBRA coverage is not required for calendar years in which the Employer has 20 or fewer Employees.*

Federal law requires some Employers sponsoring a group health plan to offer Employees and their covered dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end.

If you have questions regarding your Health Reimbursement Arrangement please contact PacificSource Administrators at (800) 422-7038 or PSAcustomerservice@PacificSource.com. This Summary Plan Description does not describe your Employer's major medical or other health insurance plan.

IV. General Information about the Plan

A. 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 possibly their Spouses' and Dependents' Health Care Expenses as described in Section IV-F. Reimbursements for Health Care Expenses paid by the HRA Plan generally are excludable from taxable income.

B. When did the HRA Plan take effect?

The HRA Plan first became effective 8/1/2003.

C. Who can participate in the HRA Plan?

Employees who actually participate in the HRA Plan are called “Participants”. You are eligible to participate if you have met the required eligibility standards and waiting period as follows: Minimum of 20 hours required during each week. Employees and/or their spouse or dependents must be enrolled in this Employer's group sponsored medical plan or the group sponsored medical insurance plan of a different Employer to be reimbursed for medical care expenses under the HRA Plan.

Your “entry date” is the date in which you become eligible to participate in the HRA Plan. You may enroll in the HRA Plan as follows: First of the month following or coinciding with date of hire

The following Employees are not eligible to participate in the HRA Plan: Employees on the Non-HIP plan (PPO plan)

D. 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 Health 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.

Your Employer offers a(n) **“**Comprehensive A” Health Reimbursement Arrangement. This HRA Plan is defined as covering all unreimbursed medically necessary health expenses which reimburses all expenses as outlined in IRS Code 213, including long-term care and COBRA premiums.

D.1 Limitations on prescriptions under the HRA Plan

Reimbursement for prescriptions are: Limited to IRS Code 213 eligible expenses.

E. How will the HRA Plan work?

The HRA Plan will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA Account. If you have a claim under an insurance plan or policy, you should follow the claims procedure applicable to that plan or policy, as described in the applicable Plan Document or summary.

For claims associated solely with the Plan, you should file your claim for reimbursement as soon as possible after you have incurred the expense. A signed “Request for Reimbursement Form” is required for all requests that you submit via mail or fax. Your claim for expense reimbursement must include a statement from your service provider that you have incurred the expense and the amount of your expense. Note: In some instances, a statement from the provider that an expense is medically necessary may be required.

Claims may be submitted the following ways:

- Electronically via our secure web portal: https://hrbenefitsdirect.com/PSA/signIn.aspx
- Faxed with a reimbursement form to (866) 446-6090
- Mailed with a reimbursement form to PO Box 2797, Portland, OR 97208

Claims will be paid up to 90 days after the close of the plan year. Those submitted after the allowable year-end “run out” period may not be paid.

Note that it is not necessary for you to have actually paid the amount due for an expense; only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source.

If the Plan qualifies and the Employer offers an electronic payment card (debit card, credit card, or similar method) to pay expenses from your account, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents.

If you receive reimbursement and it is later determined that you received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to the Plan. If you do not refund the improper payment, the Plan reserves the right to offset future reimbursement equal to the improper payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, the Employer may treat the overpayment as a bad debt, which may have income tax consequences for you.

What if I have a Flexible Spending Account (FSA) in addition to my HRA Plan?
In the event that an expense is eligible for reimbursement under both the HRA and a Health FSA the Health FSA pays out first and the HRA pays out last when the Participant's medical care expenses are covered by both the HRA and the Health FSA.

E.1 Account Credits

Funding of the HRA Plan can only be made with Employer contributions. 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. Different amounts may be credited for different classes of active Participants. The HRA Plan may be subject to a maximum balance above which credits will not be made and there may be different maximums for different classes of active Participants. When carryover is allowed under your HRA Plan your maximum amount is the combined value of the carryover plus the annual credit maximum amount.

Your HRA Account will be reduced by any amount paid to you, or for your Benefit, for eligible Health Care Expenses. The amount available for reimbursement of Health 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.

Refer to Section III Plan Information at a Glance to determine your annual credit maximum amount and if the carryover option is available under your HRA Plan.

E.2 What is a carryover of Account Balance of unused funds?

If a carryover of account balance is allowed, unused amounts in a Participant's HRA do not "zero out" at the end of each year, but instead accumulate and remain available to reimburse eligible Health Care Expenses incurred in later years. The amount allowed to carryover may be subject to maximum dollar or percent limitations which could prevent a carryover of all unused amounts.

If a carryover of account balance is not allowed, unused amounts in a HRA at the end of a coverage period are forfeited, and are not available for reimbursement of expenses incurred in other coverage periods. See Section III Plan Information at a Glance for details on the carryover of account balance, if any, available under the HRA Plan.

E.3 How often will my account be credited?

Your account will be credited with Employer non-elective contributions as indicated in Section III Plan Information at a Glance. The HRA Plan will then use the total amount credited to your account to reimburse you for eligible expenses. The contribution frequency will be credited to your account on an Annual basis - funded at the start of the Plan Year.

E.4 If I am hired mid-year how will the credit be calculated?

If a Participant enters the HRA mid-year, then the Participant's maximum reimbursement dollar limit will be a pro-rated monthly contribution.

E.5 Is there any risk of losing or forfeiting the funds in my account?

Any funds not carried forward would be subject to forfeiture after the claims submission period ends.

E.6 Whose expenses are eligible for reimbursement under the HRA Plan?

Amounts in a Participant's HRA are only available to reimburse expenses incurred by covered persons. Your HRA Plan covers Employee + dependents qualified expenses.

E.7 What is a HRA Threshold?

If a Threshold Amount is designated in Section III Plan Information at a Glance, then expenses incurred by each covered Person are reimbursable under this HRA Plan only after the covered person pays their Threshold Amount out of pocket. This is the amount the Employee must pay before the HRA will reimburse. For example, if this HRA Plan has a $500 Threshold Amount, this HRA Plan will not reimburse expenses until the Participant has paid $500 dollars out of pocket. The Threshold Amount is an aggregate amount across all eligible family members

unless the HRA Plan uses individual tracking as indicated in Section III Plan Information at a Glance.

E.8 What is the reimbursement rate of eligible expenses?

Once your Threshold Amount has been met, 100% of eligible expenses of eligible Health Care Expenses will be paid up to your available account balance.

E.9 What amounts will be available from the HRA account at any particular time during the Plan Year?

Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Health Care Expenses. The amount available for reimbursement of 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.

E.10 When must the expense be incurred to be eligible for reimbursement from the HRA?

Only expenses incurred on or after your entry date and prior to the end of the Plan Year are eligible for payment. An expense is incurred on the date a service is provided or rendered and not on the date that the service is billed or paid. You may submit claims incurred during your "period of coverage" for 90 days after the period of coverage. Claims submitted beyond this "run out" period are ineligible for reimbursement. Your period of coverage is generally a Plan Year, but if you begin or end participation in the middle of the Plan Year, the period of coverage is the portion of the Plan Year during which you were a Participant in the Plan. However, some Plans do allow expenses in prior years to be eligible for reimbursement. Refer to Section III Plan Information at a Glance to determine if this option is available under your Plan.

F. Are there any limitations on Benefits available from the HRA Plan?

A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses are (a) insulin; (b) prescribed drugs and medicines (whether or not the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment.

Your Employer offers a(n) **"Comprehensive A**" Health Reimbursement Arrangement. This HRA Plan is defined as covering all unreimbursed medically necessary health expenses which reimburses all expenses as outlined in IRS Code 213, including long-term care and COBRA premiums. Your Employer or PSA can provide you with more information about which expenses are eligible for reimbursement.

Some examples of expenses that are not eligible for reimbursement include the following:

- Over-the-counter drugs or medicines that are purchased without a prescription.
- Health insurance premiums for any other plan. (Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under the Employer's major medical or other health insurance plan.)

- 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.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- 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).
- Home or automobile improvements.
- 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 if recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- 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 Internal Revenue Code (the “Code”) §213.

G. May I elect to permanently opt out of my HRA Account?

You may elect to permanently opt out of and waive any right to future reimbursements from your HRA Account. This opportunity will be offered at least annually by the HRA Plan. Your Employer will not contribute to your HRA Account after any opt-out election takes effect.

H. What if I terminate my employment or lose eligibility 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.

Upon termination of employment, you may permanently opt out and waive future reimbursements. The remaining balance of the HRA will be forfeited.

- Upon termination, HRA participation ends on the last day of the month in which the Employer has contributed.
- Upon loss of eligibility, HRA participation ends on the last day of the month in which the Employer has contributed.

H.1 If I terminate the Plan mid-year what happens to my annual credit maximum?

If you terminate employment or lose eligibility as described in Section III Plan Information at a Glance, additional credits to your account will cease. Your current Plan year annual credit maximum will be a pro-rated value based on the eligibility period.

H.2 Can I continue to be reimbursed for expenses incurred after termination of employment or loss of eligibility while still employed?

If “termination events” occur such as termination of employment or loss of eligibility while still employed, funds are generally forfeited (i.e. spend down is not allowed). Funds will remain available through the run-out period to reimburse expenses incurred before the event.

There may be a spend down period following termination of employment. If spend down is allowed some or all amounts remain available to reimburse expenses incurred after the applicable termination event. A spend down may be subject to maximum dollar, percent, time period and/or vesting schedule limitations which could limit the time or amount available to spend down the account. In addition, the expenses reimbursable under the Plan may be expanded or contracted during the spend down period. Refer to Section III Plan Information at a Glance to determine if your plan offers a spend down option; and if available, the length of the spend down period under the Plan.

H.3 What if I terminate and I am rehired?

If you terminate and are rehired within 1 month, you will immediately rejoin the Plan and be reinstated with the same HRA account balance that the individual had before termination. If you terminate and are rehired 1 month or more after the date of termination you will be treated as a new hire and must re-satisfy (complete the waiting period) the Plan eligibility requirements. Services incurred during the period of termination will not be eligible for reimbursement.

H.4 What if I lose eligibility and then later regain eligibility during the Plan Year?

If you experience a loss of eligibility and then later regain eligibility within 1 month, you will immediately rejoin the Plan and be reinstated with the same HRA account balance that the individual had before termination. If you regain eligibility 1 month or more after the loss of eligibility date you will be treated as a new hire and must re-satisfy (complete the waiting period) the Plan eligibility requirements. Services incurred during the period of termination will not be eligible for reimbursement.

I. 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? (*if applicable)*

Consolidated Omnibus Budget Reconciliation Act (COBRA) spelled out 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 Employer's major medical or other health insurance plan and 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 Employer's major medical or other health insurance plan and 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:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits;
- Your Dependent child 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 your Employer 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 who becomes 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 the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

J. Will I have any administrative costs under the HRA Plan?

Not at the present time. The Employer is currently bearing the entire cost of administering the HRA Plan while you are an eligible Employee.

K. 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.

L. Can the HRA Plan be changed?

The HRA Plan is intended to comply with all applicable sections of the Internal Revenue Code; therefore, the HRA Plan and any Employer benefit plans offered under the HRA Plan may be amended to comply with the Internal Revenue Code and the Treasury Regulations as they may be amended. In addition, the HRA Plan and any Employer benefit plans offered under the HRA Plan may be amended at any time for reasons other than compliance with new law.

M. 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 differing results. If there is any doubt, you should consult your own tax advisor.

N. 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.

N.1 When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after PSA receives 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 PSA's control, such as situations where a claim is incomplete. PSA 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 PSA 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, PSA will make the decision based on the information that it has.

N.2 What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from PSA will include the following information:

- 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;
- The specific reason for the denial;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the HRA Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA §502(a) following a denial on review; and
- If PSA 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.

N.3 Do I have a right to appeal a denied claim?

Yes, you have the right to an internal appeal and, if applicable, an external review to an independent review organization. Additional information regarding your review rights is available on request from your Employer and/or PSA.

N.4 Do I have to appeal a denied claim before I can go to court?

Generally, you will not be allowed to take legal action against the Plan, the Employer, PSA, 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 summary, 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.)

N.5 What are the requirements of my internal appeal?

Your internal appeal must be in writing, must be provided to PSA, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or PSA's act or omission;
- The date of the notice that PSA informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or PSA's act or omission.

You should also include any documentation that you have not already provided to PSA.

N.6 Is there a deadline for filing my internal appeal?

Yes. Your internal appeal must be delivered to PSA within 180 days after reviewing the denial notice or PSA'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 PSA.

N.7 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 PSA. 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, PSA 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 PSA receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for PSA's notice of final internal adverse benefit determination. Similarly, if PSA identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for PSA'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 not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the internal appeal determination will be based on the medical judgment of a health care professional retained by PSA, the health care professional retained for purposes of the internal appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

N.8 When will I be notified of the decision on my internal appeal?

You will be notified of the decision on your internal appeal within 60 days following receipt of your request for review.

N.9 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 PSA will include the following information:

- 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;
- The specific reason for the denial upon review;
- A reference to the specific HRA Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- 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;
- 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; and
- A statement of your right to bring an external appeal or a civil action under ERISA §502(a).

N.10 Do I have the right to seek review of a denied claim to an external third party?

You have the right to an external review of the denial of your claim, and any subsequent internal appeals process determination to uphold that denial, unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA Plan's eligibility requirements.

N.11 What are the requirements of an external review?

You will file a request for external review with PSA. This request should be in writing, and must include an authorization to allow PSA to share your Protected Health Information with the

external review organization. A request will not be deemed complete until such time as an authorization has been received by PSA, and the failure to timely provide such an authorization will not serve to alter the deadline to file for external review. PSA will forward any completed request to the appropriate agency within five (5) business days or less depending on the clinical urgency of the situation.

Please note that any external review is conducted in accordance with the external review process as implemented by the State where the Employer is headquartered.

N.12 Is there a deadline for filing for an external review?

Yes, your request for an external review must be filed within one hundred eighty (180) days of the date you were served with PSA's response to your internal appeal request. If you do not file your appeal within this 6 month period, you lose your right to request an external review.

N.13 When will I be notified of the decision on my external appeal?

The external reviewer must notify you and PSA of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer'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.

O. Change in Status.

A qualified change in status may allow your Employer to make a mid-plan year change or revocation to your annual credit maximum amount. The Employer, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a change in status. In this regard, a change in status is any of the following:

- An event that changes the Participant's legal marital status, including marriage, death of a spouse, legal separation, or annulment;
- An event that changes the number of the Participant's dependents, including by reason of birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events that change the employment status of the Participant or the Participant's spouse or dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in work site; and any change in employment status that causes the Participant, Participant's spouse or Participant's dependent to become (or cease to be) eligible under this Plan, any Employee Plan underlying this Plan, or any plan or Employee benefit plan of the Employer of the Participant's spouse or Participant's dependent (e.g., a change from hourly to salaried status where such change affects eligibility);
- An event which causes a dependent to satisfy or cease to satisfy the eligibility requirements for coverage due to attainment of age, student status or any similar circumstance as provided in the applicable Plan;
- A change in the place of residence of the Participant or the Participant's spouse or dependent.

If you would like to do so, you should contact the Employer as soon as possible after the event occurs, within 30 days of that event.

V. ERISA Rights

As a Participant in the HRA Plan, you may be entitled to certain rights and protection under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants are entitled to:

- Examine, without charge, at the Employers office and at other specified locations (such as worksites and union halls) all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the HRA Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports;

- Obtain copies of all plan documents and other plan information upon written request to the Employer (the Employer may charge a reasonable amount for the copies); and

- Receive a summary of the HRA Plan's annual information report (the Employer is required by law to furnish each Participant with a copy of this summary annual report).

You are entitled to continue health care coverage under COBRA for yourself, your Spouse, or your Dependents if there is a loss of coverage under the Employer's major medical or other health insurance plan and the HRA Plan as a result of a qualifying event. You, your Spouse, or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the HRA Plan for the rules governing your COBRA continuation rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your HRA Plan, called “fiduciaries” of the HRA Plan, have a duty to do so prudently and in the interest of the HRA Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may discriminate against you in any way to prevent you from obtaining a Benefit from the HRA Plan or from exercising your rights under ERISA.

If your claim for a Benefit is ignored or denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the HRA Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the HRA Plan Administrator. If you have a claim for Benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the HRA Plan, then you may file suit in state or federal court. In addition, if you disagree with the HRA Plan's decision or lack thereof regarding the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

If you have any questions about the HRA Plan, you should contact the HRA Plan Administrator. If you have any questions about this part of the Summary Plan Description or about your rights under ERISA, or if you need assistance in obtaining documents from the HRA Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

VI. HIPAA Privacy Rights

A. 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 Section VIII). For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official: CITY OF SPRINGFIELD.

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.

B. Permitted Uses and Disclosures

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- 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 Official.

C. Disclosures to 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 administration 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:

- not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;
- ensure that any agents to whom the Employer provides PHI (or certain Electronic Protected Health Information (EPHI)) received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;

- promptly report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI it learns about;
- make PHI available to you in accordance with the requirements of the Privacy Rule;
- make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- 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 purposes of determining the HRA Plan's compliance with HIPAA; and
- 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 EPHI) to the following employees and may only do so to the extent that the employees perform HRA Plan administration functions:

- The Privacy Official;
- Employees in the Employer's Human Resources Department;
- Employees in the Employer's Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

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 Official immediately.

VII. Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

Plan Administrator. The Employer.

Benefits. The reimbursement benefits for Health Care Expenses described in the HRA Plan.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code. The Internal Revenue Code of 1986, as amended.

Compensation. The wages or salary paid to an Employee by the Employer.

Dependent. A Dependent is a Participant's child as defined in Code §152(f)(1) who has not attained age 27, 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 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.

Electronic Protected Health Information or EPHI. Has the meaning described in 45 CFR §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 (as such terms are defined in HIPAA).

Eligible Employee. An Employee who has met the eligibility requirements in Section III-C

Employee. An Employee of the Employer who receives Compensation from the Employer.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Health FSA. A Health Flexible Spending Account as defined in Prop. Treas. Reg. §1.125-5(a)(1).

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

HRA Account. The recordkeeping account established in your name by the Employer on the basis of which eligible Health Care Expenses will be paid or reimbursed.

HRA Plan. The CITY OF SPRINGFIELD Health Reimbursement Arrangement (HRA) Plan, as amended or restated from time to time.

Health Care Expenses. See Section IV-F for a description of Health Care Expenses.

Participant. An Eligible Employee who becomes a Participant in the HRA Plan.

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.

Plan Information at a Glance. The outline of the parameters associated with this HRA Plan, such as the Effective Date, eligibility requirements, etc.

Plan Year. The period of 1/1/2019 through 12/31/2019.

Privacy Rule. The regulations that were issued by the Department of Health and Human Services in accordance with the requirements of HIPAA.

Spouse. An individual of same-sex or opposite sex who is legally married to a Participant as determined under applicable federal and/or state law (and who is treated as a Spouse under the Code).

Third Party Administrator. An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. For purposes of this document, the Third Party Administrator (TPA) is PacificSource Administrators, Inc.

Threshold Amount. The amount the Employee must pay before the HRA will reimburse. Expenses incurred by each covered Person are reimbursable under this Plan only after the covered person pays their Threshold Amount out of pocket. The Threshold Amount is an aggregate amount across all eligible family members unless the Plan uses individual tracking as indicated in Section III Plan Information at a Glance.

VIII. Miscellaneous

A. 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 document. The HRA Plan is not a contract of employment between you and the Employer.

B. Prohibition Against Assignment of Benefits

No Benefit 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.

C. 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.

D. Family and Medical Leave Act and USERRA (if applicable)

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain HRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

If you go on a leave of absence that is not subject to the FMLA or USERRA, you will be treated as having terminated participation.

IX. Other Notices Which May be Required by Law

A. Qualified Medical Child Support Order

The HRA Plan will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The HRA Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Employer.

B. Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)

Group health plans 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 to less than 96 hours following a cesarean 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).

C. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

D. Michelle's Law

"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

E. The Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

F. Health Information Technology for Economic and Clinical Health Act (HITECH Act)

HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

G. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.