

**SUMMARY PLAN DESCRIPTION**

**FOR**

**THE CITY OF SOUTH BEND  
FLEXIBLE BENEFITS PLAN**

**EFFECTIVE January 1, 1993  
RE-STATED January 1, 2013**

**THE CITY OF SOUTH BEND  
FLEXIBLE BENEFITS PLAN  
SUMMARY PLAN DESCRIPTION**

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## **I. INTRODUCTION**

THE CITY OF SOUTH BEND (the Employer) sponsors and is the Plan Administrator for THE CITY OF SOUTH BEND FLEXIBLE BENEFITS PLAN (the Plan) that allows eligible Employees to purchase coverage for health care and other qualified benefits with pre-tax dollars through special types of spending accounts. The advantage of these spending accounts is that you pay no federal taxes on the contributions you make. This means a higher take-home pay for you than if you purchased health coverage or paid for unreimbursed medical and/or dependent care expenses with after-tax dollars. This Summary describes the basic features of the Flexible Benefits Plan and how it operates. This Summary does not describe every detail of the Plan. If there is a conflict between the Flexible Benefits Plan Document and this Summary, then the Plan Document will control.

## **II. WHO IS ELIGIBLE TO ENROLL IN THE PLAN**

Employees who are regularly schedule to work 40 or more hours per week provided that the election procedures under "How to Enroll" are followed. To participant in either the Dependent Care Account or the Health Flexible Spending Account in the upcoming flex plan year, the employee must also have been hired by October 1 of the prior year for enrollment as of January 1 in either account.

An "Employee" is an individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Employees, do not, however, include the following: (a) any common-law employee who is a lease employee or any common-law employee classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee, even if such an individual is later reclassified as a common-law employee; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency; (c) any employee covered under a collective bargaining agreement; or (d) any self-employed individual, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

## **III. HOW TO ENROLL**

After you become eligible, you must select which benefits you would like to purchase through the Plan. Your decision must be made at your initial eligibility or during the month preceding the Plan Year for which it will be in effect. Each year, THE CITY OF SOUTH BEND will provide you with a written election form that will enable you to identify the benefits in which you wish to participate and the portion of your compensation reduction that may be applied to provide each benefit. You must complete the form and return it to the Human Resources Office within the time period specified in the enrollment materials.

If for some reason, as a newly eligible employee, you fail to complete an election form, then you will be deemed to have elected cash compensation to the extent permissible. If you are already a

Plan participant and you fail to complete an election form for the upcoming Plan Year, you will maintain the medical, dental, and/or vision benefit options that you elected for the prior year, but will not be eligible to participate in either Spending Account.

#### **IV. PRE-TAXED CONTRIBUTIONS**

When you elect to pay for benefits on a pre-tax basis, you agree to a salary reduction in order to pay for your share of the cost of coverage (also known as contributions) for your group health plan coverage and to set aside pre-tax dollars to pay for medical expenses and/or eligible child care expenses that are not reimbursed from any other source, instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. Generally, you have an equal portion deducted pre-tax from each paycheck, or by an amount otherwise agreed to or as deemed appropriate by the Plan Administrator.

#### **V. BENEFITS ELECTED UNDER THE FLEXIBLE BENEFITS PLAN**

Benefits may be purchased through the Flexible Benefits Plan with pre-tax income. Details relative to the cost per pay period for each benefit and the minimum and maximum amounts you may contribute to the Spending Accounts are provided by THE CITY OF SOUTH BEND on the election form and/ or on Appendix A and Appendix B. The benefits from which you may choose include:

- A medical plan
- A dental plan
- A vision plan
- Two different spending accounts:
  - A medical spending account
  - A dependent care spending account

Each benefit under the Flexible Benefits Plan has separate rules governing benefits and plan administration that are explained in more detail in the plan documents. A copy of all of this information is available from the Human Resources Department of THE CITY OF SOUTH BEND.

There are some expenses you know you will have to pay for in the coming year (for example, new eyeglasses, medical and dental care expenses not covered by the health plan, or perhaps care for a child or an incapacitated dependent adult while you are at work). Normally you would pay for expenses like these with after-tax income. And, because taxes reduce the value of your dollar, you would have to earn considerably more than \$100 to pay for \$100 of expenses.

If you are eligible to participate, THE CITY OF SOUTH BEND Flexible Benefits Plan allows you to contribute pre-tax income to create special accounts in order to reimburse yourself on a pre-tax basis for payment of certain medical and dependent care expenses. It is like getting a discount on these

bills since you do not have to earn as much money to pay for them. The money you contribute to spending accounts by automatic payroll deduction is not subject to Federal or Social Security taxes, but depending on your residence, may be subject to state and local income taxes.

### **How Medical and Dependent Care Spending Accounts Work**

You may establish spending accounts for two separate categories of predictable expenses—medical and dependent care. Once you have determined your annual predictable expenses for the period of time covered by the Plan Year, a portion of that amount may be paid for with pre-tax dollars, deposited on a per-pay basis to the spending account you have elected. The Internal Revenue Code Section 125 states that these balances cannot be combined or used for purposes other than that for which they were originally intended.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the designated claims administration representative. THE CITY OF SOUTH BEND has designated North America Administrators (NAA) as the claims administration representative. (PLEASE NOTE: If you participate in THE CITY OF SOUTH BEND Employee Benefits Plan, and North America Administrators also processes your medical claims, those claims will automatically “roll over” to your Health Flexible Spending Account for payment of any co-insurance and/or deductible amounts, UNLESS you also have secondary insurance coverage or specifically request that the automatic rollover be blocked.) Once the claims administration representative receives the claims, they will be processed for reimbursement on a weekly basis. Upon submission of a claim to your Health Flexible Spending Account, you will be reimbursed the full amount of your eligible expenses up to your elected Health Flexible Spending Account pre-tax deferral amount. However, you must have accumulated a sufficient credit balance in your Dependent Care Amount in order to receive full reimbursement; otherwise, you will receive partial reimbursement with the remaining portion of the claim automatically considered for reimbursement in subsequent weeks as more dollars are contributed from your pay to your Dependent Care Account.

### **The Health Flexible Spending Account**

Under this category are expenses such as deductibles and co-payments, uninsured medical expenses, including over-the-counter medications purchased to alleviate or treat personal injuries or sickness of the employee, spouse, or dependent. PLEASE NOTE that over-the counter (OTC) drugs and medicines (other than insulin) may only be reimbursed if you have a written prescription, regardless of whether or not the drug or medicine requires a prescription. Other reimbursable expenses may also include certain transportation costs to receive medical care, dental expenses, vision care and hearing care. Generally, covered expenses are “medically necessary” or prescribed

by a licensed physician. Please see the attached Appendix C for a list of common covered expenses. Covered expenses *do not include* premiums paid for other health plan coverage, including plans maintained by the employer of your spouse or dependents, or for expenses such as the following examples. If you have a question about whether or not an expense is reimbursable, you may contact NAA at 800-411-3650.

- Cosmetic surgery that is any procedure 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.
- Tattoo removal
- Maternity clothes
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. While the objective of these reimbursements is to help you to maintain good health through preventive care, it is important not to overestimate your needs, because the tax law requires unused amounts in your spending accounts to be forfeited at the end of each Plan Year.

### **The Dependent Care Spending Account**

Dependents are defined for this purpose as children up to age 13, handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return. If dependent care is required to enable you (and, if married, your spouse) to work (or, if married, to allow your spouse to attend school full-time), these expenses may be eligible for reimbursement. Included are payments to childcare centers, nursery schools, kindergarten and schools for children up to but not including first grade. Eligible expenses also include payment for summer day camps, after-school care and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a non-relative, as long as such a person is reporting payments as income, is also eligible.

Be aware that you may be able to take a federal tax credit (Dependent Care Credit) for eligible expenses up to \$3,000 (for one dependent) or \$6,000 (for more than one dependent). The credit equals 35% of expenses, reduced by one percentage point (but not to drop below 20%) for each \$2,000 (or fraction) by which your adjusted gross income exceeds \$15,000. Any amounts deferred to a Dependent Care Spending Account will reduce dollar-for-dollar the maximum allowable expense

under the tax credit. For more information about how the Dependent Care Credit works, see IRS Publication No. 503 (“Child and Dependent Care Expenses”). You may also wish to consult a tax advisor.

### **Spending Accounts – Other Facts to Consider**

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on flexible spending accounts:

- You must use all of the funds in your spending accounts by the end of the Plan Year or you will lose them (the use-it-or-lose-it rule).
- The balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses.
- You will receive statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year, or be forfeited. You may continue to submit claims up to 90 days after the Plan Year ends for the prior year’s expenses. Employees who terminate employment during the Plan Year will have until the 90<sup>th</sup> day following their date of termination to submit expenses incurred prior to their termination. (NOTE: Medical and dependent care expenses are considered to be “incurred” when care is provided, not when you are formally billed, charged for, or pay for the care. However, certain orthodontia expenses are considered “incurred” when you make the advance payment.)
- According to government regulations, the annual maximum pre-tax contribution you can make is \$2,500.

## **VI. CHANGING ELECTIONS DURING THE PLAN YEAR**

Generally, your choices are in effect for the entire Plan Year. *Only under special circumstances* may you apply to change your selected benefits. The change must be consistent with the change event, to the extent that it is necessary or appropriate as a result of the change.

Permitted change in election events may include: a significant increase in the cost of coverage, a change in status, such as your legal marital status; a change in the number of your dependents; an event that causes your Dependent to satisfy or cease to satisfy eligibility requirements for a particular benefit; FMLA leave; HIPAA special enrollment rights; COBRA qualifying event; Judgments, Decrees or Orders, including a qualified medical child support order (QMCSO) described in ERISA Section 609; and entitlement to (or loss of entitlement) Medicare, Medicaid, or a state children’s health insurance plan (CHIP).

Should you experience a change, as described above, you must notify THE CITY OF SOUTH BEND within 30 days of the occurrence if you wish to change the corresponding elections. However, any event that results in a Dependent becoming ineligible will result in an automatic corresponding change of election under the Plan as of the date of the event. If the change event is entitlement to (i.e., enrollment in) (or loss of entitlement to) Medicaid or a state children's health insurance plan (CHIP), you will be allowed 60 days from the date of the event in which to make the corresponding Plan change. Contact your Human Resource Office immediately if you believe you have experienced a mid-year change event that will allow you to change your elections.

#### **VII. WHEN PARTICIPATION IN THE PLAN CEASES**

An Employee continues to participate in the Plan until (a) termination of the Plan; (b) the date on which he ceases to be an eligible Employee (due to retirement, termination of employment, layoff, reduction of hours, or any other reason); or (c) the date on which he elects not to participate in the Plan, either at the annual open enrollment period or due to a permitted mid-year change event.

If your employment with THE CITY OF SOUTH BEND is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more pre-tax contributions to the Plan. (See Section VIII for information on your right to continued group coverage under the Health FSA, if any, after termination of your employment.) If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, your prior elections will be reinstated; you may not make any *new* elections, unless there has been a permitted mid-year change event as outlined above.

Notwithstanding any information in this Summary Plan Description and the Flexible Benefit Plan Document regarding your rights under USERRA (Uniformed Services Employment and Reemployment Act) and FMLA, if you become unable to make the required contributions for the Plan, your benefits will cease at that time. You will not be able to resume pre-tax payment of premiums until the next Plan Year and may be required to complete the waiting period.

#### **VIII. COBRA CONTINUATION COVERAGE**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." The Employee, Spouse, and dependent children could become qualified beneficiaries if coverage under the Plan is lost due to a qualifying event. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights as any other Participant or beneficiary covered under the Plan.

Employees will become a qualified beneficiary if coverage is lost under the Plan due to either of the following qualifying events:

- a) Termination of employment (except for termination due to gross misconduct); or
- b) Reduction in hours of employment.

The Spouse of an Employee will become a qualified beneficiary if coverage is lost under the Plan due to any of the following qualifying events:

- a) Employee dies;
- b) Employee's hours of employment are reduced;
- c) Employee's employment ends for any reason other than gross misconduct; or
- d) Divorce or legal separation. Also, if the Employee reduces or eliminates Spouse's group health 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 the Spouse even though coverage was reduced or eliminated before the divorce or legal separation.

A dependent child of an Employee will become a qualified beneficiary if coverage is lost under the Plan due to any of the following qualifying events:

- a) Employee dies;
- b) Employee's hours of employment are reduced;
- c) Employee's employment ends for any reason other than gross misconduct;
- d) Employee becomes divorced or legally separated; or
- e) Child is no longer eligible for coverage under the Plan as a dependent child.

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.

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 Plan Administrator during the covered Employee's period of employment with the Employer is entitled to the same rights under COBRA as a dependent child of the covered Employee, regardless of whether that child would otherwise be considered a dependent.

COBRA continuation coverage for the Health FSA is available only if there is a positive Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event) and only until the end of the Flex Plan Year in which the qualifying event occurs. COBRA coverage for the Health FSA will be the 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. Unless otherwise elected, the Spouse and dependents of the person electing COBRA will be covered, too. Each beneficiary has separate election rights and could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium.

The monthly COBRA premium is 102% of the monthly contribution that the Employee was paying via salary reductions before the date of the qualifying event. The Health FSA COBRA premium must be paid by check with after-tax dollars, unless permitted otherwise by the Administrator on a uniform and consistent basis (but not beyond the current Plan Year). COBRA coverage will terminate at the end of the Flex Plan Year. See the Plan Administrator for more information.

**IX. ABOUT SOCIAL SECURITY TAXES**

Social Security taxes are not deducted from the amount you contribute on a pre-tax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base (TWB). The TWB is adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If you are below the TWB, the benefit would be reduced. The tax advantages you gain through the Flexible Benefits Plan may offset any possible reduction in Social Security benefits.

**X. FUTURE OF THE FLEXIBLE BENEFITS PLAN**

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. THE CITY OF SOUTH BEND reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

**XI. FAMILY AND MEDICAL LEAVE**

As an employee of THE CITY OF SOUTH BEND, you may be entitled under the federal Family and Medical Leave Act (FMLA) to up to 12 work-weeks of unpaid, job-protected leave in any 12-month

period. You may be eligible if you have worked for THE CITY OF SOUTH BEND for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent), a personal serious health condition, or as a result of any “qualifying exigency” because an immediate family member is on active duty or notified of an impending call to duty. You may be eligible for up to 26 weeks of leave to care for a service member injured during active duty.

As a participant in the premium conversion component (for medical and dental benefits) part of the Flexible Benefits Plan, while on leave under the FMLA you have the option to continue your benefits on the same terms and conditions as immediately prior to your taking FMLA leave. You and your eligible dependents may remain covered under this plan while you are on FMLA leave as if you still were at work. Your coverage may be maintained until you return to work or, if earlier, you notify THE CITY OF SOUTH BEND that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before or at the end of FMLA leave, you and your eligible dependents shall immediately become covered under the plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave.

As a participant in the Health FSA, while on leave under the FMLA you have the option to continue your health benefits on the same terms and conditions as immediately prior to your taking FMLA leave (NOTE: Under certain, limited circumstances it may be possible to continue coverage under the Dependent Care Spending Account.. See the Plan Administrator for more details). You and your eligible dependents may remain covered under this plan while you are on FMLA leave as if you still were at work. Your coverage will be maintained until you return to work or, if earlier, you notify THE CITY OF SOUTH BEND that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before or at the end of FMLA leave, you and your eligible dependents will immediately become covered under the Plan. More details on your FMLA rights and benefits while on FMLA leave, including payment options, are available from your Human Resources Office.

## **XII. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

If you are absent from work due to a period of active duty in the military (as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may elect to continue participation in the Plan with the same rights and privileges as outlined for FMLA or any such *unpaid* leave. You will be responsible for making the required contributions during the period you are in “uniformed service”. Your options for payment are the same as those available for FMLA Leave. If

your participation is terminated on account of being in “uniformed service”, and is later reinstated, you will not be subject to a new exclusion or waiting period requirement.

### **Qualified Reservist Distributions**

If you meet all of the following requirements, you may elect to receive a distribution of funds from your Health FSA account for a Plan Year.

- Your contributions to your Health FSA as of the date of your request for a Qualified Reservist Distribution exceed reimbursements from your Health FSA.
- You have been ordered or called to active military duty for a period of at least 180 days or for an indefinite period because you are a member of the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.
- You provide a copy of the order or call to active duty.
- During the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year in which the order or call occurred, you deliver to the Administrator a written request for a Qualified Reservist Distribution.

The Administrator will review all requests for Qualified Reservist Distributions on a uniform and consistent basis. If approved, your distribution will be paid within 60 days after the date of your request. The amount available to you will be the amount you have contributed to your Health FSA as of the date of the Distribution Request, minus any reimbursements received as of the date of the distribution. Any portion of the distribution that is not a reimbursement for substantiated medical care expenses will be included in your gross income. For additional information regarding Qualified Reservist Distributions, you may refer to the Plan Document.

### **XIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a “qualified medical child support order” (QMCSO). Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an “alternate recipient” to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An “alternate recipient” is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant’s group health plan.

A medical child support order satisfies certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

#### **XIV. MATERNITY AND NEWBORN COVERAGE**

Since this Plan offers maternity and newborn coverage, you are advised that under Federal law, this Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from this Plan or its Administrator or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. 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 the above periods.

#### **XV. CLAIMS FILING & PROCEDURES TO FOLLOW IN THE EVENT A CLAIM IS DENIED**

To receive benefits under the Plan, you must submit a written claim for benefits to the Claims Administrator, NORTH AMERICA ADMINISTRATORS. However, if you also participate in THE CITY OF SOUTH BEND Employee Benefit Plan, your claims automatically will be considered for any reimbursement payable from your Health FSA, unless the claim is subject to coordination of benefits under another health plan or you specifically request that the automatic process be blocked.

When you submit a claim for reimbursement from your Health FSA or Dependent Care Account, you must provide the following by no later than 90 days following the close of the Plan Year in which the expense was incurred:

- The individual(s) on whose behalf the expenses have been incurred;
- The nature and date of the expenses;
- The amount of the requested reimbursement; and
- A statement that the expenses have not otherwise been reimbursed and reimbursement will not be sought through any other source.

You must also include paid invoices, Explanation of Benefits forms, receipts, or other statements from an independent third party showing that the expenses have been incurred and the amounts of such expenses.

The Claims Administrator will review the claim and will advise you of any Benefit to which you are entitled. Additionally, the Claims Administrator will provide every claimant who is denied a claim for Benefits a written notice stating:

- The specific reason or reasons for the denial;

- Specific reference to the Plan language or Section 125 regulations on which the denial is based;
- A description of any additional material or information necessary for the claimant to provide so the claim may be processed for reimbursement, and an explanation of why such material or information is necessary; and
- An explanation of the claim review procedures.

Notice will be given 30 days after the claim is received by the Claims Administrator (or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of the extension and circumstances is given to you within the initial 30 days period). If notification is not given within the time period, the claim will be considered denied as of the last day of the time period. You may then request a review of the claim.

Within 180 days of your receipt of a notice denying a claim, you or your duly authorized representative may request in writing a full and fair review of the claim by the Claims Administrator, action on behalf of the Plan Administrator. In connection with the review, you or your duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Plan Administrator will make a decision promptly and not later than 60 days after the Claim Administrator's receipt of a request for review. The decision on review will be in writing and will include specific reasons for the decision and with specific references to the Plan provisions and/or Section 125 regulations on which the decision is based. If the decision on review affirms the initial denial of the claim, you or your duly authorized representative will be furnished with a notice of adverse benefit determination on review setting forth:

- a. The specific reason(s) for the decision on review;
- b. The specific information on which the decision is based;
- c. A statement of your right to review (upon request and at no charge) relevant documents and other information;
- d. If an "internal rule, guideline, protocol, or other similar criterion" is relied upon in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- e. A statement of your right to bring suit under ERISA 502(a) (where applicable).

If you are denied a benefit under the Flexible Benefits Plan the following procedures will apply. You will be notified in writing within 30 days after the date the Claims Administrator received your

claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete.) The Claims Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will set out:

1. A specific reason or reasons for the denial;
2. The specific Plan provision on which the denial is based;
3. A description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
4. Appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

If your claim is denied in whole or in part, you (or your authorized representative) have 180 days from the receipt of the decision to submit a written appeal to the Plan Administrator for a review of the denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons you believe your claim should not have been denied. It should include any additional facts and/or documents that you believe support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

The Plan Administrator will make a decision not later than 60 days after receipt of your written request for review. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review that will include the following:

1. The specific reason(s) for the decision on review;
2. The specific Plan provision(s) on which the decision is based;
3. A statement of your right to review (upon request and at no charge) relevant documents and other information;
4. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol or other similar

criterion (or a statement that such a rule, guideline, protocol or other similar criterion was relied on) and a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

5. A statement of your right to bring suit under ERISA section 502(a), if applicable.

**XVI. INSURANCE CONTRACTS**

Any monies refunded to the Employer or a Participating Employer due to actuarial error in the rate calculation will be the property of and retained by the Employer or the Participating Employer.

**XVII. ADMINISTRATIVE COSTS**

The cost of administering the Flexible Benefits Plan is paid entirely by the Employer.

**XVIII. ADMINISTRATIVE FACTS**

**Plan Sponsor and Administrator**

The information furnished herein constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished. Note: Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA).

**Name and Identification Number of Plans**

The CITY OF SOUTH BEND Flexible Benefits Plan (506), The CITY OF SOUTH BEND Dependent Care Assistance Plan (507) and the CITY OF SOUTH BEND Health Flexible Spending Plan (508).

**Participants**

The plan provides benefits for all employees of the CITY OF SOUTH BEND who meet the eligibility requirements described herein.

**Plan Administrator**

The CITY OF SOUTH BEND  
227 W Jefferson Blvd, 12<sup>th</sup> Floor  
South Bend, IN 46601  
Phone: 574-235-9931

**Employer Identification Number (EIN)**

35-6001201

## **Agent for Service of Legal Process**

Director of Human Resources  
The CITY OF SOUTH BEND  
227 W Jefferson Blvd, 12<sup>th</sup> Floor  
South Bend, IN 46601  
Phone: 574-235-9931

## **Plan Year**

January 1 through December 31

## **Plan Definition and Funding**

This is a Section 125 flexible benefits plan classified as a “cafeteria” plan by the Internal Revenue Code. It includes a Section 105 Health Flexible Spending Account, classified by the Department of Labor as a “welfare” plan, and a Section 129 Dependent Care Flexible Spending Account. The Plan is funded by both employer and employee contributions.

## **Health Insurance Plan Administrator**

The CITY OF SOUTH BEND Employee Health Care Plan is a self-funded health insurance plan. The City is the Plan Administrator.

## **Not a Contract of Employment**

No provision of the Plan is to be considered a contract of employment between you and the CITY OF SOUTH BEND or a Participating Employer. The rights of the CITY OF SOUTH BEND with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

## **XIX. HIPAA PRIVACY AND SECURITY**

**Employer’s Certification of Compliance.** The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR 164.504(f)(2)(ii) and the Employer agrees to conditions of disclosure set forth in this Section 7.

**Permitted Disclosure of Enrollment/Disenrollment Information.** The Plan may disclose to the Employer information on whether an individual is a Participant in the Plan.

**Permitted Uses and Disclosures of Summary Health Information.** The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. “Summary Health Information” means information: (a) that summarized the claims history, claims expenses, or type of

claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

**Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes.** Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for the Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Section 7 (including, but not limited to, the restrictions on the Employer's use and disclosure described in Section 7.5) and the specifications and requirements of the administrative simplification provisions of HIPAA and its implementing regulations at 45 CFR Parts 160-64.

**Restrictions on Employer's Use and Disclosure of Protected Health Information.** Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.

1. Employer will ensure that any agent, including any subcontractor, to which it provided a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to the Protected health Information or Electronic Protected Health Information, respectively.
2. Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.
3. Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the plan document of which the Employer becomes aware.
4. Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45CFR 164.524

5. Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 CFR 164.526.
6. Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 CFR 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR 164.528.
7. Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164, Subpart E.
8. Employer will, if feasible, return or destroy all Protected health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived there from that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.
9. Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR 504(f)(2)(iii), is satisfied.

**Adequate Separation between Employer and the Plan.**

1. Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan:
  - Privacy Official;
  - Employees in the Employer's Human Resources Department;
  - Employees in the Employer's Office of General Counsel (if applicable); and,
  - Any other class of employees designated in writing by the Privacy Official.
2. The employees, classes of employees, or other workforce members identified in Section

12.6(a) will have access to a Covered Individual's Protected Health Information or Electronic Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 12.4.

3. The employees, classes of employees, or other workforce members identified in Section 12.6(a) will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of this Section 12.

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

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

**Release of information.** For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *Participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy and security standards*. Any *Participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

## XX. ERISA RIGHTS STATEMENT

The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee who is a Participant in the Plan is entitled to certain rights and protections under ERISA, which provide that all Participants will be entitled to:

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

Plan records are kept on a Plan Year basis. In addition to creating rights for plan participants, ERISA imposes duties upon those responsible for the operation of a plan who are called “fiduciaries” and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit under the Plan is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA, there are steps an Employee covered under a plan may take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require THE CITY OF SOUTH BEND to provide the materials and pay the person up to \$110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the control of THE CITY OF SOUTH BEND

If a person has a claim for benefits that is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if an Employee covered under this Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claim to be frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), 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.

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan.

**XXI. THIS IS A SUMMARY PLAN DESCRIPTION ONLY**

Your specific rights to benefits under the Plan are governed solely, and in every respect, by THE CITY OF SOUTH BEND Flex Plan Document, a copy of which is available from the Human Resources Office upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.

**CITY OF SOUTH BEND FLEXIBLE BENEFITS PLAN  
APPENDIX A  
EMPLOYER AND EMPLOYEE CONTRIBUTION LIMITATIONS**

***Benefit Options***

***Employee Contributions***

Health Flexible Spending Account

Employee’s designated salary reduction and allocation subject to the limitations set forth on Appendix B.

Dependent Care Spending Account

Employee’s designated salary reduction and allocation subject to the limitations set forth on Appendix B.

**Benefit Options – Pre-Taxed Premiums Only**

CITY OF SOUTH BEND Medical Plan

Employee Only	*
Employee and Children	*
Employee and Spouse	*
Employee and Family	*

CITY OF SOUTH BEND Dental Plan

Employee Only	*
Employee and Children	*
Employee and Spouse	*
Employee and Family	*

CITY OF SOUTH BEND Vision Plan

Employee Only	*
Employee and Children	*
Employee and Spouse	*
Employee and Family	*

\*The Employee contributions necessary to obtain the coverages set forth in this Appendix A above will be communicated by the Employer to Eligible Employees upon commencement of participation and to Participants at the time of the Enrollment Period. The Employee contribution required to obtain coverage under any of the above will be the maximum elected contributions required for coverage under such options.

**CITY OF SOUTH BEND  
FLEXIBLE BENEFITS PLAN**

**APPENDIX B  
EMPLOYEE CONTRIBUTION LIMITATIONS**

	<i>Minimum*</i>	<i>Maximum*</i>
Health Flexible Spending Account (Extra Flex)	\$8.33	\$100.00
Dependent Care Account	\$8.33	\$208.33

\*Per Bi-Weekly pay. (NOTE: Annual minimum is \$200. Annual maximum is \$2,400. Annual maximum for Dependent Care Account is \$5,000 (if single or married, filing jointly). Based on 24 pay periods, above amounts reflect actual minimum and maximum compensation reductions allowable, as compensation reductions may not exceed employee's annual election.

**THE CITY OF SOUTH BEND  
FLEXIBLE BENEFITS PLAN**

**APPENDIX C  
HEALTH FSA COVERED EXPENSES**

The products and services listed below are examples of medical expenses eligible for payment under a Health FSA to the extent that such services are not covered by your medical, dental, and vision insurance plan (if applicable). This list is not all-inclusive. Additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations.

**\*NOTE: As of 1/1/2011, OTC drugs and medicines (other than insulin) require a written prescription.**

**Dental Services**

- Crowns/Bridges
- Dental X-rays
- Dentures
- Exams/Teeth Cleaning
- Extractions
- Fillings
- Gum Treatment
- Oral Surgery
- Orthodontia/Braces

**Insurance Related Items**

- Copay Amounts
- Deductibles
- Pre-existing Condition Expenses (medical)
- Private Hospital Room Differential

**Lab Exams/Tests**

- Blood Tests
- Cardiographs
- Diagnostic
- Laboratory Fees
- Metabolism Tests
- Spinal Fluid Tests
- Urine/Stool Analyses
- X-rays

**Medications**

- Insulin
- Prescribed Birth Control
- Prescribed Vitamins (to treat specific disease and not available over-the-counter)
- Prescription Drugs
- **Over-the-Counter Drugs**

**Obstetric Services**

- Midwife Expenses
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Post-natal Treatment/Pre-natal Treatment (excludes over-the-counter vitamins)

- Pre-natal vitamins (prescription only)

**Practitioners**

- Allergist
- Chiropractor
- Christian Science
- Dermatologist
- Homeopath
- Naturopath
- Osteopath
- Physician
- Psychiatrist
- Psychologist

**Other Medical Treatments or Procedures**

- Acupuncture
- Alcoholism (inpatient treatment)
- Cosmetic Surgery (if medically necessary)
- Drug Addiction
- Hearing Exams
- Hospital Services
- Infertility
- In-vitro Fertilization
- Norplant Insertion or Removal
- Patterning Exercises
- Physical Examination (if not employment related)
- Physical Therapy
- Pregnancy Test (over-the-counter)
- Rolfing
- Smoking Cessation Programs
- Speech Therapy
- Sterilization
- Transplants (including organ donor)
- Treatment for Handicapped
- Vaccinations/Immunizations
- Vasectomy
- Well Baby Care

**Other Medical Equipment, Supplies, and Services**

- Abdominal/Back Supports
- **Allergy Medication (over-the-counter)**
- Ambulance Services
- **Antacids (over-the-counter)**
- Arches/Orthopedic Shoes
- **Cold Medications (over-the-counter)**
- Contraceptives
- Counseling
- Crutches
- Guide Dog (for visually/hearing impaired person)
- Hearing Aids and Batteries
- Hospital Bed
- Learning Disability (special school/teacher)
- Medic Alert Bracelet or Necklace
- Mileage to/from Physician Visit at \$.12 per mile
- Oxygen Equipment
- **Pain Relievers (over-the-counter)**
- Prosthesis
- Splints/Casts
- Support Hose (if medically necessary)
- Syringes
- Transportation Expenses (essential to medical care)
- Tuition Fee at Special School for Disabled Child
- Wheelchair
- Wigs (hair loss due to disease)

**Vision Services**

- Contact Lenses
- Contact Lens Solution
- Eye Examinations
- Eyeglasses
- Laser Eye Surgeries
- Ophthalmologist
- Optometrist
- Prescription Sunglasses
- Radial Kerotomy