



## **City of Jackson**

Welfare Benefits Plan

### **Summary Plan Description**

Amended and Restated Effective  
January 1st, 2020

161 W. Michigan Avenue  
Jackson, MI 49201

**Third Party Administrator**



**BENEFIT MANAGEMENT, INC.**

**100 S. Jackson, Suite 200  
P.O. Box 189  
Jackson, MI 49204  
(800) 589-7660 or (517) 784-0535**

Introduction.....4

Purpose of This Wrap SPD Document .....4

General Information about the Plan.....5

Eligibility and Participation .....8

Identifying Employee Eligibility – Look Back Measurement Period Method.....8

Need for Enrollment: Time Limits .....11

Special Enrollment Rights .....11

When Participation Begins.....11

Termination of Participation .....12

Disclosures for Group Health Plans .....12

Qualified Medical Child Support Order (QMCSO) SPD .....12

Required Coverage for Adopted Children .....12

Required Coverage for Dependent Students (Michelle’s Law).....12

Required Coverage of Certain Pediatric Vaccines .....13

The Mental Health Parity Act (MHPA).....13

The Mental Health Parity and Addiction Equity Act (MHPAEA).....13

The Women’s Health and Cancer Rights Act of 1998 (WHCRA).....13

The Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA).....13

The Family and Medical Leave Act of 1993 (FMLA) .....14

Uniformed Services Employment and Reemployment Rights Act (USERRA).....14

Age Discrimination in Employment Act of 1967 (ADEA).....15

Americans with Disabilities Act of 1990 (ADA) .....16

Title VII of the Civil Rights Act and the Pregnancy Discrimination Act (PDA).....16

The Genetic Information Nondiscrimination Act (GINA).....16

Medicare Secondary Payer MSP Requirements.....16

Medicare Part D Creditable Coverage and Coordination of Benefits Disclosures .....17

HMO Nondiscrimination Requirement Disclosure .....17

TRICARE: Incentive Prohibition and Nondiscrimination Requirements.....17

Health Information Technology for Economic and Clinical Health Act (HITECH).....18

Continuation Coverage Rights Under Cobra .....18

Compliance With HIPAA Privacy Standards .....26

Compliance With HIPAA Electronic Security Standards.....27

Special Enrollment Periods.....28

Available Benefits and Contributions.....28

How the Plan Is Administered .....28

Plan Operations .....28

Plan Administration.....28

Power and Authority of Insurance Companies.....29

Your Questions.....29

Denial, Recovery, or Loss of Benefits .....29

Administrative Requirements and Timelines .....29

Amendment or Termination of the Plan .....30

No Contract of Employment .....30

Claims for Fully Insured Benefits .....31

Claims for Self-Funded Benefits.....31

Statement of ERISA Rights .....32

Your Rights.....32

Receive Information about Your Plan and Benefits .....32

Prudent Actions by Plan Fiduciaries.....32

Enforce Your Rights.....32

Assistance with Your Questions.....32

Employee Benefits Acronyms.....34

## Introduction

The City maintains the Plan for the exclusive benefit of its eligible full-time or part-time employees and their spouses and dependents. The Plan provides benefits through the following component benefit programs:

- **Health FSA (Flexible Spending Account) Plan**
- **Dependent Care Assistance Program (DCAP)**
- **Self Insured Medical Insurance Benefit**
- **Health Reimbursement Account (HRA)**
- **Self Insured Dental Benefit**
- **Self Insured Vision Benefit**
- **Voluntary Life Benefit**
- **Insured Long-Term Disability Insurance Benefit**
- **Group Term Life Insurance & Group Accidental Death & Dismemberment Benefit**

Some of these component benefit programs require completion of application forms, annual elections, and/or other administrative forms. The details of these administrative requirements are described in the enrollment packets or available with the online enrollment system.

Each of the component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description (SPD) prepared specifically for that component benefit program, or another written governing document prepared by the City. A copy of each booklet, summary, or other governing document is attached to this document in the Attachments.

## Purpose of This Wrap SPD Document

You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Attachments. This document, together with the Attachments, is the SPD required by **ERISA §102**. This document is not intended to give you any substantive rights to benefits that are not already provided by the Attachments. If you have not received a copy of the Attachments, contact Jonathan Greene at City of Jackson.

**You must read the Attachments and this Wrap SPD to understand your benefits!**

### Electronic Forms

To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

## General Information about the Plan

<b>Plan Name:</b>	City of Jackson Welfare Benefits Plan.
<b>Type of Plan:</b>	The Plan is a welfare plan that provides Health FSA, medical, dental, vision, health reimbursement account HRA, long-term disability, group term life and accidental death & dismemberment benefits. Note: The Plan also includes a cafeteria plan under <b>Code §125</b> and DCAP under <b>Code §129</b> . The cafeteria plan and DCAP are not subject to ERISA.
<b>Plan Year:</b>	July 1 <sup>st</sup> through June 30th
<b>Plan Number:</b>	501
<b>Effective Date:</b>	The effective date of the Plan amendment/restatement is July 1, 2015.
<b>Grandfathered Status:</b>	<p>The City believes the component benefit program through which medical coverage is provided is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.</p> <p>Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at City of Jackson, Attention: Jonathan Greene, 161 W Michigan Avenue, Jackson, MI 49201. Because the component benefit program through which medical coverage is provided is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.</p>
<b>Funding Medium &amp; Type of Plan Administration:</b>	<p>Some benefits under the Plan are self-funded, and other benefits are fully insured. As discussed below under the heading “How the Plan Is Administered,” the City and the insurance companies share responsibility for administering the component benefit programs under the Plan.</p> <p>The medical, dental, and vision insurance component along with the health reimbursement account HRA benefit program is Self Funded. The long-term disability, group term life, and accidental death &amp; dismemberment programs are fully insured.</p>

The flexible spending and DCAP accounts are funded with employee contributions only.

The City is responsible for paying claims with respect to the self-funded component benefit programs. The insurance companies, not the City, are responsible for paying claims with respect to the insured component benefit programs.

Insurance premiums for employees and their eligible family members are paid in part by the City out of its general assets and in part by employees on a pre-tax basis through the cafeteria plan component benefit program. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable. Contributions are also made by employees on a pre-tax basis through the cafeteria plan component benefit program under the Plan. Neither the Plan nor any of the component benefit programs offered through it have a trust.

**Plan Sponsor:** **City of Jackson**  
**161 W. Michigan Avenue**  
**Jackson, MI 49201**  
(517)788-4046

**Employer Identification #:** **38-6004701**

**Insurance Companies:** Benefits are provided through insurance contracts with the Insurance Companies listed below.

1. Mutual of Omaha
  - a. Group Life & Accidental Death & Dismemberment
  - b. Long Term Disability

**Self Funded Benefits:** Self-funded benefits are provided by City of Jackson and listed below.

1. Health Insurance
2. Dental Insurance
3. Vision Insurance
4. Health Reimbursement Account HRA

**Employee Paid Benefits:** Employee Contributions fund the following benefits listed below.

1. Flexible Spending Account FSA
  - a. Medical Reimbursement
  - b. Dependent Day Care
2. Mutual of Omaha
  - a. Voluntary Life Insurance

**Plan Administrator:** **City of Jackson**  
**161 W. Michigan Avenue**  
**Jackson, MI 49201**  
(517)788-4046

**Named Fiduciary:**

*(Benefit Claims)*

**City of Jackson  
161 W. Michigan Avenue  
Jackson, MI 49201  
(517)788-4046**

*(Insured Claims)*

For each of the insured component benefit programs, the Insurance Company is a Named Fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

**Agent for Service of  
Legal Process:**

**City of Jackson  
161 W. Michigan Avenue  
Jackson, MI 49201  
(517)788-4046**

Service for legal process may also be made on the Plan Administrator.

**Claims Administrator  
Third Party Administrator  
(TPA):**

**JFP Benefit Management, Inc.  
100 S. Jackson Street – Suite 200  
PO Box 189  
Jackson, MI 49204  
(517) 784-0535 or (800) 589-7660**

**Important Disclaimer:**

Benefits hereunder are provided pursuant to an insurance contract or governing written plan document adopted by the City. If the terms of this Wrap SPD document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this Wrap SPD document, unless otherwise required by law.

## **Eligibility and Participation**

An eligible employee with respect to the Plan is any common-law employee of the City who is eligible to participate in and receive benefits under one or more of the component benefit programs. The eligibility and participation requirements may vary depending on the particular component program. You must satisfy the eligibility requirements under a particular component benefit program in order to receive benefits under that program. A summary of this information is set forth below.

An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.).

For Plan Years beginning before January 1, 2015, an Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices. For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least 3 but not more than 12 consecutive months for purposes of determining an employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods). See Identifying Employee Eligibility.

### **Identifying Employee Eligibility – Look Back Measurement Period Method**

A full-time employee is an employee who is employed, on average, for at least 30 hours of service per week or 130 hours of service in a calendar month.

Effective 07/1/15, the City will use a Transition look-back measurement method to determine whether an employee is a full-time employee for purposes of Plan coverage. The Transition look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA) and will apply to all City employees.

The look-back measurement method involves three different periods:

- A measurement period for counting an employee's hours of service (also called a standard measurement period or an initial measurement period);
- A stability period when the employee is either treated as full-time or non-full-time for Plan eligibility purposes; and
- An administrative period that allows time for Plan enrollment and disenrollment.

### **Ongoing Employees**

For ongoing employees, the City determines full-time status by looking at a standard measurement period (SMP) lasting 12 consecutive months. The standard measurement period (SMP) starts on May 1st and ends on April 30th (5/1 through 4/30). The administrative period will last 61 days. The stability period will be 12 months, subject to specified IRS parameters.



An employee's hours of service during the standard measurement period (SMP) will determine his or her Plan eligibility for the stability period that follows the standard measurement period (SMP).

An ongoing employee is one who has been employed by the City for at least one complete standard measurement period (SMP). If an ongoing employee was employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the standard measurement period (SMP), the employee is treated as a full-time employee for a set period into the future, known as the stability period.

This means that, as a general rule, the employee is eligible for Plan coverage during the stability period, regardless of the employee's number of hours of service during the stability period, as long as he or she remains an employee.

The final IRS regulations include an exception for certain employees who have been continuously offered Plan coverage and who transfer to part-time positions during the stability period. If certain conditions are met, Plan eligibility for these transferred employees may end during a stability period. The City intends to follow applicable IRS guidance, including the rules for changes in employment status, when administering the look-back measurement method.

If an ongoing employee was not employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the standard measurement period (SMP), the employee is not treated as a full-time employee during the stability period, regardless of the employee's number of hours of service during the stability period.

### **New Employees Expected to Work Full Time**

For a new employee who is not a seasonal employee and who the City reasonably expects at his or her start date to be a full-time employee, the City will determine the employee's status as a full-time employee based on the employee's hours of service for each calendar month.

If the employee's hours of service for the calendar month equal or exceed an average of 30 hours of service per week (or 130 hours per month), the employee is a full-time employee for that calendar month. Once the new employee becomes an ongoing employee (that is, he or she is employed for at least one complete standard measurement period (SMP)), the measurement rules for ongoing employees will apply.

### **New Variable Hour, Seasonal or Part-time Employees**

Under the look-back measurement method, the City determines whether new variable hour employees, new seasonal employees and new part-time employees are full-time employees by measuring their hours of service during an initial measurement period or (IMP).

- An employee is a **variable hour employee** if, at the employee's start date, the City cannot determine whether the employee is reasonably expected to be employed, on average, at least 30 hours per week because the employee's hours are variable or otherwise uncertain.
- A **seasonal employee** is generally an employee who is hired into a position for which the customary annual employment is six months or less. Also, the period of employment for a seasonal employee should begin each calendar year in approximately the same part of the year, such as summer or winter.
- A **part-time employee** is a new employee who the City reasonably expects to be employed, on average, less than 30 hours per week during the initial measurement period (IMP).

Similar to the method for ongoing employees, the look-back measurement method for new variable hour, seasonal and part-time employees utilizes a stability period for when coverage may need to be provided, depending on the employee's hours of service during the initial measurement period (IMP). An administrative period is also used to make eligibility determinations and notify and enroll employees.

The Initial Measurement Period (IMP) lasts 12 months and begins on the first day of the month following hire. The initial measurement period will be immediately followed by a 30 day administrative period.

If a new variable hour, seasonal or part-time employee was employed, on average, at least 30 hours of service per week (or 130 hours per month) during the initial measurement period (IMP) the employee is treated as a full-time employee for a set period into the future, known as the **stability period**. This means that the employee is eligible for Plan coverage during the stability period, regardless of the number of hours of service during the stability period, as long as he or she remains an employee.

If a new variable hour, seasonal or part-time employee was not employed, on average, at least 30 hours of service per week (or 130 hours per month) during the initial measurement period (IMP) the employee is not treated as a full-time employee during the stability period, regardless of the employee's number of hours of service during the stability period.

The final IRS regulations contain special rules for a new variable hour, seasonal or part-time employee who, before the end of the initial measurement period (IMP) changes employment to a position or status where if the employee had started employment in the new position or status, he or she would have reasonably been expected to be employed full time as a non-seasonal employee. The City intends to follow applicable IRS guidance, including the special rules for changes in employment status, when administering the look-back measurement method.

The initial stability period will be twelve (12) months and begins on the first day of the month after the initial administrative period.

Once a new variable hour, seasonal or part-time employee has been employed for an entire standard measurement period; the employee will be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees.

### **Rehired Employees and Employees Returning from Unpaid Leave**

The following rules apply to rehired employees and employees returning from unpaid leave:

- If an employee goes at least 13 consecutive weeks without an hour of service and then earns an hour of service, he or she is treated as a new employee for purposes of determining the employee's full-time status under the look-back measurement method.

The City will apply a rule of parity for periods of less than 13 weeks. Under the rule of parity, an employee is treated as a new employee if the period with no credited hours of service is at least four weeks long and is longer than the employee's period of employment immediately before the period with no credited hours of service.

- For an employee who is treated as a continuing employee, the measurement and stability periods that would have applied to the employee had he or she not experienced the break in service will continue to apply upon the employee's resumption of service.

In addition, a special averaging method applies when measurement periods include special unpaid leave (that is, leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) or jury duty leave). This method only applies to an employee who is treated as a continuing employee upon resuming services for the employer, and not to an employee who is treated as terminated and rehired.

Under the averaging method, the City will either:

- Determine the average hours of service per week for the employee during the measurement period, excluding the special unpaid leave period, and use that average as the average for the entire measurement period; or
- Treat employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.

**Effective Date of Employee Coverage.** An Employee’s coverage will take effect on the day that the Eligibility Requirements are met per the schedule listed below.

Benefit	Who Is Eligible	When Participation Begins
Medical	All Full time employees	First day of Full Time Employment
Prescription	All Full time employees	First day of Full Time Employment
Health Reimbursement Account HRA	All Full time employees & under age 65 retirees that have coverage under the Blue Cross & Blue Shield of Michigan high deductible health plan	First day of Full Time Employment
Dental	All Full time employees	First day of Full Time Employment
Life & Accidental Death & Dismemberment	All Full time employees	First day of Full Time Employment
Long Term Disability	All Full time employees	First day of Full Time Employment
Flexible Spending Account	All Full time employees	First open enrollment following full time employment
Vision	All Full time employees	First day of Full Time Employment
Supplemental Life Insurance	All Full time employees	First day of Full Time Employment

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

### Need for Enrollment: Time Limits

In general, eligible employees must complete an application (either personally or with assistance of Jonathan Greene, Cheri Rayner, or Doria LaPorte of City of Jackson) to enroll themselves and/or their eligible spouses and dependents. New employees must generally enroll within certain time periods after being hired. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before July 1 of each year.

### Special Enrollment Rights

In certain circumstances and with respect to particular component benefit programs, enrollment may occur at times outside the open enrollment period (this is referred to as “special enrollment”). The Plan's Special Enrollment Notice also contains important information about your potential special enrollment rights. Contact Jonathan Greene of City of Jackson if you need another copy.

### When Participation Begins

Once you, as an eligible employee, have completed the necessary enrollment paperwork, your coverage under the Plan may begin. Requirements may vary depending on the component benefit program.

## Termination of Participation

In general, your coverage under this Plan terminates on the day in which you terminate employment with the City, unless otherwise indicated in contract. Coverage also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons.

Coverage for your spouse and dependents stops when your coverage stops and for other reasons (for example, divorce or a dependent's attaining age limit). Coverage also ceases for employees, spouses, and dependents upon termination of the Plan.

Coverage under a particular component benefit program stops according to the terms and conditions reflected in the Attachments. Note that termination of coverage under a particular component benefit program does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another component benefit program.

## Disclosures for Group Health Plans

### Qualified Medical Child Support Order (QMCSO) SPD

Every group health plan that is subject to ERISA is required to provide benefits in accordance with the applicable requirements of a qualified medical child support order (QMCSO). QMCSOs are judgments, decrees, or orders (issued by a court or through a state administrative process) that require a group health plan to provide coverage to a participant's child (an alternate recipient) and meet other specific requirements (see subsections C and D for more details). QMCSOs typically require the group health plan of a child's noncustodial parent to provide coverage to the child, even though the child may not be a "dependent" under the plan's definition.

Group health plans may also receive National Medical Support Notices (NMSNs). NMSNs are standardized medical child support orders that are used by state child support enforcement agencies to obtain group health coverage for children. An appropriately completed NMSN is deemed to be a QMCSO and an ERISA group health plan must comply with it, including state and local governmental plans and church plans that aren't otherwise subject to ERISA.

### Required Coverage for Adopted Children

An ERISA group health plan that provides coverage for the dependent children of participants or beneficiaries must also provide coverage to dependent children who are placed with participants or beneficiaries for adoption. Such coverage must be provided under the same terms and conditions that apply to dependent children who are the natural children of participants or beneficiaries, regardless of whether or not the adoption has become final.

### Required Coverage for Dependent Students (Michelle's Law)

Under Michelle's Law, group health plans that are subject to ERISA and certain other laws must allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence. Specifically, a group health plan (or health insurer that provides health insurance coverage in connection with the plan) cannot terminate coverage of a dependent child due to a medically necessary leave of absence before the earlier of the date that is one year after the first day of the leave of absence, or the date on which coverage would otherwise terminate. This law, also known as Michelle's Law, became effective for plan years beginning on or after October 9, 2009 (calendar-year plans had to comply beginning January 1, 2010) and to medically necessary leaves of absence beginning during such plan years.

A dependent child under Michelle's Law is a beneficiary under the group health plan who is a dependent child under the plan or coverage of a participant or beneficiary (typically a parent), and was enrolled in the plan or coverage as a student at a post-secondary educational institution (e.g., colleges and universities) immediately before the first day of the medically necessary leave of absence. A medically necessary leave of absence is a leave of absence of the child from the institution, or any other change in enrollment of the child, that commences while the child is suffering from a serious illness or injury, is medically necessary, and causes loss of student status.

### Required Coverage of Certain Pediatric Vaccines

A group health plan subject to ERISA may not reduce its coverage of the costs of pediatric vaccines (as defined under §1928(h) (6) of the Social Security Act as amended by §13830 of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)) below the coverage that it provided as of May 1, 1993. OBRA '93 also made the pediatric vaccines requirement applicable to state and local governmental group health plans via the federal Public Health Service Act (PHSA).

The pediatric vaccines covered by **ERISA §609(d)** are based on the list established (and periodically reviewed and as appropriate, revised) by the Advisory Committee on Immunization Practices, acting through the Director of the Centers for Disease Control and Prevention. This list is available through the website of the Advisory Committee on Immunization Practices.

### The Mental Health Parity Act (MHPA)

The mental health parity requirements began with the Mental Health Parity Act (MHPA) of 1996. MHPA requires a group health plan with annual dollar limits or aggregate lifetime dollar limits for “medical/surgical benefits” to apply those same (or higher) dollar limits to “mental health benefits.”

### The Mental Health Parity and Addiction Equity Act (MHPAEA)

Congress passed additional parity requirements in the second statute, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Some refer to this statute as the “Wellstone Act.” The MHPAEA added provisions relating to “substance use disorder benefits” and imposed additional parity requirements in connection with financial requirements and treatment limitations, as well as aggregate lifetime and dollar limits. These additional requirements first apply for plan years beginning after October 3, 2009 (for calendar-year plans, January 1, 2010).

### The Women’s Health and Cancer Rights Act of 1998 (WHCRA)

WHCRA requires group health plans (and health insurance issuers providing coverage in connection with a group health plan) that provide medical and surgical benefits for a mastectomy to provide, in the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast “to produce a symmetrical appearance”; and prostheses and physical complications of mastectomy, including lymphedemas.

### The Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) provides that group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a vaginal delivery, to less than 48 hours, or following a cesarean section, to less than 96 hours. 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).

A group health plan may also not require a physician or other health care provider to obtain authorization from the plan for prescribing the minimum hospital stay for the mother or newborn.

### The Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) generally requires covered employers to permit eligible employees to take up to 12 workweeks in any 12 months of unpaid, job-protected leave each year because of the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of their own serious health condition. The FMLA also permits an eligible employee to take up to 12 workweeks of leave during any 12-month period for a “qualifying exigency” arising because a spouse, son, daughter, or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces. In addition, an eligible employee who is the spouse, son, daughter, parent or next of kin of a “covered service member” is entitled to up to 26 workweeks of leave during a single 12-month period to care for the service member with a serious injury or illness. Subject to certain conditions, instead of taking an unpaid leave, employees or employers may choose to use accrued paid leave (such as sick leave or vacation leave) to cover some or all of the FMLA leave. A covered employer is required to maintain group health plan benefits for an employee on FMLA leave on the same terms and conditions as if the employee had continued to work during the leave. When the employee returns from FMLA leave, the employer must restore the employee’s group health coverage and other benefits.

*Only eligible employees are entitled to take FMLA leave. An eligible employee is one who:*

- *Works for a covered employer;*
- *Has worked for the employer for at least 12 months;*
- *Has at least 1,250 hours of service for the employer during the 12 month period immediately preceding the leave; and*
- *Works at a location where the employer has at least 50 employees within 75 miles.*

### Uniformed Services Employment and Reemployment Rights Act (USERRA)

An employee who has coverage under a health plan (or whose dependents are covered) in connection with his or her position of employment may elect continuation coverage under USERRA (for the covered employee and dependents) if he or she will be absent from employment for uniformed service.

You may elect to continue health coverage under the Plan for yourself and your eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day you are absent from work to perform military service, or
- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

If you give advance notice of a period of military service that will be 30 days or less, the Plan Administrator will treat your notice as an election to continue your health coverage during your military service (unless you specifically inform the Plan Administrator, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give advance notice of a period of military service that will be 31 days or more, the Plan Administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents that are covered under the Plan when your military service begins.



If you choose USERRA continuation coverage, you must return the USERRA election form to the plan administrator within 60 days of the date it was provided to you. If you do not return the election form within the 60 day timeframe, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give the Plan Administrator advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your health coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g. it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity).
- You affirmatively elect to reinstate the coverage; and
- You pay all unpaid premiums for the retroactive coverage.

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly situated active participants. If your period of military service is more than 30 days, beginning on the 31<sup>st</sup> day your required contributions will be 102% of the cost of identical coverage for similarly situated active participants (or the current COBRA rate).

USERRA continuation coverage will be cancelled if you do not pay any required premiums within the timeframe allowed for payment of the coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30 day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elected USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may reenroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods, except for illnesses or injuries connected to the military service.

### **Age Discrimination in Employment Act of 1967 (ADEA)**

**ADEA Applies to Employee Benefits.** The phrase “compensation, terms, conditions, or privileges of employment” encompasses all employee benefits, including benefits provided under a bona fide employee benefit plan, in addition to actions involving hiring, firing, promotion, layoff, compensation, job assignments, and training. The ADEA applies even if the employer isn't required to provide the benefit.

**Employers are prohibited from** engaging in any of the following activities:

- failing or refusing to hire or to discharge an individual, or otherwise discriminating against an individual with respect to the “compensation, terms, conditions, or privileges of employment” because of such individual's age;

- limiting, segregating, or classifying employees in any way that would deprive or tend to deprive them of employment opportunities or otherwise affecting their status because of age; or
- reducing the wage rate of any employee in order to comply with the ADEA.

### Americans with Disabilities Act of 1990 (ADA)

Under the Americans with Disabilities Act of 1990 (ADA), as amended by the Americans With Disabilities Act of 2008 (the ADA Amendments Act),<sup>2</sup> an employer may not discriminate against a qualified individual on the basis of disability, with respect to numerous items affecting group health plans, including the following:

- fringe benefits available by virtue of employment, whether or not administered by the covered entity; and
- any other term, condition, or privilege of employment.

### Title VII of the Civil Rights Act and the Pregnancy Discrimination Act (PDA)

Under Title VII of the Civil Rights Act of 1964, employers are prohibited from engaging in any of the following activities:

- failing or refusing to hire or discharge an individual, or otherwise discriminating against an individual with respect to the “compensation, terms, conditions, or privileges of employment” because of such individual’s race, color, religion, sex, or national origin; or
- limiting, segregating, or classifying employees in any way that would deprive or tend to deprive them of employment opportunities or otherwise affecting their status because of race, color, religion, sex, or national origin.

As amended by the Pregnancy Discrimination Act of 1978 (PDA), Title VII also prohibits discrimination “because of or on the basis of pregnancy, childbirth, or related medical conditions.” It provides that “women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected” but who are otherwise similar in their ability or inability to work.

### The Genetic Information Nondiscrimination Act (GINA)

The Genetic Nondiscrimination Act of 2008 (GINA) prevents discrimination in health insurance based on genetic information. GINA imposes restrictions on group health plans, group health insurance issuers, and insurance issuers in the individual market to prohibit against:

- using genetic information to discriminate with respect to premium or contribution amounts;
- requesting or requiring that individuals or their family members undergo genetic testing (with limited exceptions);
- collecting (by requesting, requiring or purchasing) genetic information for underwriting purposes and collecting genetic information with respect to any individual prior to enrollment or coverage under the health plan; and
- using genetic information to determine eligibility for coverage.

Genetic information includes any information about an individual’s own genetic tests, the genetic tests of an individual’s family members, and the manifestation of a disease or disorder in the individual’s family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations, or chromosomal changes—essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition.

### Medicare Secondary Payer MSP Requirements

The MSP rules specify when a group health plan must pay primary and when it may pay secondary if an individual is covered under both a group health plan and Medicare. The rules also provide that employers



may not offer individuals entitled to Medicare financial or other incentives to opt out of employer-provided group health coverage, and they prohibit certain actions that “take into account” an individual’s Medicare entitlement. The MSP rules were added to Section 1862(b) of the Social Security Act in 1980.

### Medicare Part D Creditable Coverage and Coordination of Benefits Disclosures

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit (Part D) to the Medicare program for certain individuals. Group health plan sponsors that provide prescription drug coverage to individuals who are eligible for coverage under Part D are subject to certain mandates under Part D. “*Part D eligible individuals*” individuals who have coverage under Medicare Part A or Part B, which may include active employees, disabled employees, COBRA participants, retirees, and their covered spouses and dependents) became eligible to enroll in Part D beginning in 2006.

Part D imposes the following requirements that will affect group health plan sponsors providing prescription drug coverage to Part D eligible individuals:

- group health plan sponsors must disclose to Part D eligible individuals and to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is “creditable” (i.e., whether its actuarial value equals or exceeds the actuarial value of defined standard Part D coverage) —such disclosures must be made through notices, the form and content of which has been prescribed by CMS (the disclosure requirements); and
- group health plans will need to cooperate with Part D plans and Part D enrollees in order to coordinate benefits (the COB requirements).

### HMO Nondiscrimination Requirement Disclosure

Employers that choose to offer a federally qualified health maintenance organization (HMO) to their eligible employees are subject to the following nondiscrimination requirements:

- The employer must give each eligible employee or eligible dependent who lives in the HMO’s service area the opportunity to enroll in the HMO;
- The employer must, if requested by a federally qualified HMO, give employees who enroll in the HMO the opportunity to enroll in “free-standing” dental, optical, or prescription drug benefits if those benefits aren’t available under the HMO and are being offered separately from the employer’s “basic health benefits package” or “major medical plan”;
- The employer may not “financially discriminate” against the HMO option with respect to the amount of the contributions it makes toward the cost of its employees’ coverage under its group health plans; and
- The employer must allow employees who enroll in the HMO to pay their share of the cost of coverage through payroll deductions if payroll deductions are permitted for other health benefits or if employees aren’t required to contribute to the cost of other health benefit plans.

The practical effect of the HMO nondiscrimination requirement is that generally, an employer may not offer an HMO on a basis that is less favorable than the basis on which other group health options are being offered by the employer.

### TRICARE: Incentive Prohibition and Nondiscrimination Requirements

Under statutory amendments enacted in 2006, and final regulations issued in 2010, employers are prohibited from engaging in certain activities with respect to employees who are eligible for coverage under the military’s health care program known as TRICARE. In particular, employers are prohibited from:

- providing financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a health plan which would (in the case of such enrollment) be a primary plan (the incentive prohibition);

- **DOD** regulations regarding the TRICARE incentive prohibition provide that if an incentive is offered to all employees under a “cafeteria plan” to opt out of coverage, it can be offered to TRICARE eligible employees as well.
- depriving a TRICARE-eligible employee of the opportunity to elect to participate in the group health plan offered by his or her employer and to receive primary coverage under the plan in the same manner and to the same extent as similarly situated employees of the employer who are not TRICARE eligible (the nondiscrimination requirements).

## Health Information Technology for Economic and Clinical Health Act (HITECH)

Health Information Technology for Economic and Clinical Health Act (**HITECH Act** or "The Act") is part of the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA contains incentives related to health care information technology in general (e.g. creation of a national health care infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.

Because this legislation anticipates a massive expansion in the exchange of electronic protected health information (ePHI), the **HITECH Act** also widens the scope of privacy and security protections available under HIPAA; it increases the potential legal liability for non-compliance; and it provides for more enforcement.

## Continuation Coverage Rights Under Cobra

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is City of Jackson, 161 W. Michigan Avenue, Jackson, MI 49201 (517)788-4046. COBRA continuation coverage for the Plan is administered by JFP Benefit Management, Inc., P.O. Box 189 - 100 S. Jackson Street, Suite 200, Jackson, Michigan 49204, (517) 784-0535 or (800) 589-7660. Complete instructions on COBRA, as well as election forms and other information, will be provided to Plan Participants who become Qualified Beneficiaries under COBRA.

**What is COBRA continuation coverage?** COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

**Who can become a Qualified Beneficiary?** In general, a Qualified Beneficiary can be:

- Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the

Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

***Qualifying Events for the Covered Employee.*** If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

***Qualifying Events for the Covered Spouse.*** If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your 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 you even though your coverage was reduced or eliminated before the divorce or separation.

***“Qualifying Events for the Covered Dependent.”*** If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct; or
- you stop being eligible for coverage under the Plan as a “dependent child.”

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (“FMLA”) does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends

due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

**What is the procedure for obtaining COBRA continuation coverage?** The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

**The Trade Act of 2002** includes three provisions that affect COBRA, with respect to certain trade-displaced workers:

- a health coverage tax credit (HCTC) to assist with the cost of COBRA and certain other types of health coverage;
- a program for advance payment of the HCTC (HCTC Program); and
- a special second COBRA election period, including a HIPAA creditable coverage adjustment for those who elect COBRA during the special second election period.

These three provisions—the HCTC, the HCTC Program, and the special second COBRA election period—apply to different but overlapping groups of individuals and have different but interrelated conditions for applicability.

Trade Adjustment Assistance Reauthorization Act of 2015, passed as part of the Trade Preferences Extension Act of 2015, signed on June 29, 2015, restored the HCTC for all eligible coverage months beginning before January 1, 2020. The 2015 law extending the HCTC modifies several provisions to address changes made by health care reform. Further guidance is expected, but the following subsections provide an overview of the primary changes.

### **HCTC Election Required**

Eligible individuals must make an affirmative election in order for the HCTC to apply. Except as the IRS may provide, the election for an eligible coverage month in a tax year must be made no later than the due date (including extensions) of the tax return for the year. The election will apply to all subsequent eligible coverage months in the tax year and, once made, will be irrevocable with respect to those months. Further guidance is anticipated on the election process. **Qualified Health Insurance” Will Not Include Coverage Through an Exchange.**

The HCTC is available only to offset premiums paid by an eligible individual for “qualified health insurance. COBRA coverage is one type of qualified health insurance, but other types of coverage qualify as well. The new law specifies that, beginning in 2016, individual coverage purchased through an Exchange is excluded from the list of qualified health insurance for which the HCTC may be claimed.

### **Coordination With Premium Tax Credit**

To prevent “double-dipping,” the new law coordinates the HCTC with the premium tax credit available under health care reform. The premium tax credit is not available for any months for which an individual’s HCTC election applies, and individuals receiving both the HCTC and a premium subsidy through an Exchange will need to make adjustments on their tax return.

### **Transition Rules**

Transition rules are provided for tax years beginning after December 31, 2013 (the HCTC’s prior expiration date) and June 29, 2015 (the enactment date of the extending legislation). Individuals wishing to elect the HCTC for eligible coverage months within that period may elect the credit by filing an amended tax return within the three-year statute of limitations period for each tax return. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

#### **The Employer must notify the Plan Administrator of the following:**

- the end of employment or reduction of hours of employment,
- death of the employee,
- commencement of a proceeding in bankruptcy with respect to the employer, or
- enrollment of the employee in any part of Medicare.

#### **You must notify the Plan Administrator of the following:**

- You must notify the Plan Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both)
- You must notify the Plan Administrator in writing within 30 days if you become eligible or become covered under other group health plan coverage.
- If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

### **IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.**



## ***NOTICE PROCEDURES***

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

JFP Benefit Management, Inc.  
P.O. Box 189 - 100 S. Jackson Street, Suite 200  
Jackson, Michigan 49204

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- The last day of the applicable maximum coverage period.

- The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.
- The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What are the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.



**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

**Does the Plan require payment for COBRA continuation coverage?** For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

**Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **Compliance With HIPAA Privacy Standards**

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
  - (a) **Updates Required.** The Employer shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
    - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

- (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
  - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
  - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
  - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
  - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
  - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
  - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
  - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
  - (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

The following members of City of Jackson workforce are designated as authorized to receive Protected Health Information from City of Jackson Welfare Benefits Plan in order to perform their duties with respect to the Plan: Jonathan Greene – Director of Human Resources, Cheri Rayner – Human Resource Manager, and Doria LaPorte – Labor Relations Technician.

### **Compliance With HIPAA Electronic Security Standards**

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the following provisions apply:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

## Special Enrollment Periods

If an individual experiences a loss of coverage or if an employee has a new dependent, an eligible employee and/or a dependent may have special enrollment rights to participate in the group health plan immediately without being required to wait until the next annual open enrollment period.

## Available Benefits and Contributions

The Plan provides you and your eligible spouse and/or dependents with medical, dental, vision, long-term disability, group term life and accidental death & dismemberment insurance. The Plan also provides you with the opportunity to participate in the Health FSA and DCAP. A summary of each component benefit program provided under the Plan is set forth in the Attachments.

In general, the cost of the benefits provided through the component benefit programs will be funded in part by City contributions and in part by pre-tax employee contributions. The City will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The City will make its contributions in an amount that (in the City's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. With respect to the insured component benefit programs, the City will pay its contribution and your contributions to the insurer. With respect to benefits that are self-funded, the City will use these contributions to pay benefits directly to (or on behalf of) you or your eligible family members from the City's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using City contributions to pay for the cost of such benefit.

## How the Plan Is Administered

### Plan Operations

Because benefits under the Plan are provided both through insurance contracts and on a self-funded basis, the Plan is administered by City of Jackson and the insurance companies.

### Plan Administration

City of Jackson is the Plan Administrator. As the Plan Administrator, City of Jackson is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs). Jonathan Greene of City of Jackson is the person who acts on behalf of the Plan Administrator.

City of Jackson has agreed to indemnify Jonathan Greene, Cheri Rayner, and Doria LaPorte for any liability that they incur as a result of acting on behalf of the Plan Administrator, unless such liability is due to their gross negligence or misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The City will bear its incidental costs of administering the Plan.

The Health FSA plan and DCAP are self-funded by the Employees.

## Power and Authority of Insurance Companies

Certain benefits under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between City of Jackson and the Insurance Companies. Claims for benefits are sent to the Insurance Companies. The Insurance Companies are responsible for determining and paying claims, not City of Jackson.

The Insurance Companies are responsible for (a) determining eligibility for a benefit and the amount of any benefits payable under the Plan; and (b) providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

As the Named Fiduciary for benefit determinations, the Insurance Companies have the discretionary authority to interpret the Plan in order to make benefit determinations. The Insurance Companies also have the authority to require eligible individuals to furnish them with such information as they determine necessary for the proper administration of the Plan.

## Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan, or the amount of any benefit payable under the self-funded component benefit plans), please contact Jonathan Greene, Cheri Rayner, or Doria LaPorte, who acts on behalf of the Plan Administrator.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact JFP Benefit Management, Inc. or the appropriate Insurance Company.

## Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4.

Your benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits.

## Administrative Requirements and Timelines

As described in the Attachments, there may be other reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied.

## Amendment or Termination of the Plan

City of Jackson, as the sponsor of the Plan, has the general right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the City Manager, who is authorized to amend or terminate the Plan and to sign insurance contracts with the insurance companies, including amendments to those contracts.

Note, for this purpose, that an insurance contract is not necessarily the same as the Plan. (An insurance contract is how benefits under a particular component program offered through the Plan are provided.) Consequently, termination of an insurance contract does not necessarily terminate the Plan.

The City, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the City or any of its delegates.

Jonathan Greene of the City may sign insurance contracts for the Plan on behalf of the City, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he considers to be administrative in nature or advisable in order to comply with applicable law.

## No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the City to the effect that you will be employed for any specific period of time.

## Claims for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan).

## Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the City's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA.

If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).



## Statement of ERISA Rights

### Your Rights

*Note that the cafeteria plan and the DCAP component benefit programs are not covered by ERISA and this Statement of ERISA Rights does not apply to these Programs.*

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case City of Jackson, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

### Prudent Actions by Plan Fiduciaries

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

### Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the 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 City of Jackson, as Plan Administrator, to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 10), you may file suit in a state or federal court.

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

### Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the 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 contact 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.

## Employee Benefits Acronyms

“**ADA**” means Americans with Disabilities Act of 1990.

“**AD&D**” means accidental death and dismemberment insurance.

“**ADEA**” means Age Discrimination in Employment Act.

“**Attachments**” means the documentation attached to this document which together with this document constitute the written plan.

“**Cafeteria Plan**” means the plan, established by the Company under a separate document (included as an Attachment), through which choices of and pre-tax payment for benefits are made in accordance with Code §125.

“**CHAMPUS**” Civilian Health and Medical Program of the Uniformed Services (now TRICARE).

“**CMS**” means Centers for Medicare And Medicaid Services.

**COBRA**” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“**Code**” means the Internal Revenue Code of 1986, as amended.

“**Company**” means City of Jackson.

“**Covered Person**” means any Eligible Employee covered under the Plan, and any individual who is eligible for and covered under the Plan due to the individual's relationship to an Eligible Employee (such as the Employee's spouse, child, or other eligible family member). If a benefit requires enrollment, only an individual who has enrolled is considered a Covered Person with respect to that benefit.

“**DCAP**” means the dependent care assistance program established by the Company under a separate document. The DCAP is a component benefit program under the Plan. It allows Eligible Employees to use pre-tax dollars to pay for eligible expenses related to child care and adult care that are not reimbursed or paid under other programs.

“**Effective Date**” means, for this amendment and restatement, July 1, 2015. The Plan has been amended several times since the original effective date.

“**Eligible Employee**” means an Employee who satisfies the eligibility provisions of Article 3, including the eligibility provisions of the applicable component benefit program.

“**Employee**” means any common-law employee of the Company. The determination of whether an individual is an Employee, an independent contractor or any other classification of worker or service provider, and the determination of whether an individual is classified as a member of any particular classification of employees shall be made solely in accordance with the classifications used by the Company and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

“**ePHI**” means electronic protected health information.

“**ERISA**” means the Employee Retirement Income Security Act of 1974, as amended.

“**FMLA**” means the Family and Medical Leave Act of 1993.

“**GINA**” means the Genetic Information Nondiscrimination Act of 2008.

“**HCTC**” means the Health Coverage Tax Credit.

“**Health FSA**” means the health flexible spending arrangement established by the Company under a separate document (included as an Attachment). The Health FSA is a component benefit program under the Plan. It

allows employees to use pre-tax dollars to pay for certain medical and dental expenses not reimbursed or paid under other programs.

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“**HITECH**” means the Health Information Technology for Economic and Clinical Health Act.

“**HMO**” means Health Maintenance Organization.

“**IMP**” means initial measurement period as defined by Health Care Reform.

“**MHPA**” means the Mental Health Parity Act of 1996.

“**MHPAEA**” means the Mental Health Parity and Addiction Equity Act of 2008.

“**Michelle's Law**” means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

“**MSP**” means the Medicare Secondary Payer Requirements.

“**MEDICARE PART D**” means Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Coverage through Medicare.

“**NMHPA**” means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

“**PDA**” means Title VII of the Civil Rights Act and the Pregnancy Discrimination Act.

“**Plan**” means this City of Jackson Welfare Benefits Plan.

“**Plan Administrator**” means City of Jackson.

“**Plan Sponsor**” means City of Jackson.

“**Plan Year**” means the 12-month period beginning each July 1 and ending each June 30.

“**PPACA**” means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

“**QMCSO**” means Qualified Medical Child Support Order.

“**SMP**” means a standard measurement period as defined by Health Care Reform.

“**SPD**” means Summary Plan Description.

“**TPA**” means Third Party Administrator.

“**TRICARE**” means triple option benefit plan for military families (formerly CHAMPUS)

“**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994.

“**WHCRA**” means the Women's Health and Cancer Rights Act of 1998.