CITY OF IOWA CITY

FLEXIBLE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2020

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INTRODUCTION

Many employees don't view their benefits as compensation. They see pay and benefits as two separate programs. Actually, your pay and benefits together form your total compensation.

With the Flexible Benefit Plan, you receive more choices in your benefit program and more flexibility in how your total compensation is allocated between pay and benefits. The Plan allows you to elect certain optional nontaxable benefits as alternatives to cash compensation that would be taxable. As a result, your total compensation is delivered more tax effectively.

ELIGIBILITY

Employees are not automatically eligible for the Flexible Benefit Plan. Rules regarding eligibility and participation are defined below. Sole proprietors, partners in a partnership arrangement and owners of 2% or more of the shares of a Sub-S corporation are not eligible to participate.

Eligible Employee

Any individual who is employed as a permanent non-bargaining unit employee.

A bargaining unit employee of the Employer, if eligibility for the Flexible Benefit Plan is required by the applicable bargaining agreement.

Waiting Period

Eligible Employees may begin participation on the first day of the month following or coincident with hire by the City.

CONTRIBUTIONS: SALARY REDUCTION

The Flexible Benefit Plan allows you to elect to have a portion of your pay set aside (before any taxes have been deducted) to be applied to the payment of your share of the cost for the Optional Benefits you select. The legal term for this process is "salary reduction." The advantage is that it reduces your federal and state income taxes and social security taxes (FICA).

Maximum Salary Reduction Contribution

The maximum contribution under this Plan for any Participant for a Plan Year is the sum of the maximum Health Care FSA and Dependent Care FSA elections which are shown in the respective sections of this SPD plus the amount required to fully pay the Participant's share of the cost for benefits under any Premium Conversion Optional Benefit available through the Plan as defined in annual benefit enrollment material.

Social Security Impact

It should be noted that because the amount of your salary reduction is not subject to FICA taxes, it is also not included in determining your average wages for Social Security benefit purposes. For example, if you reduce your salary in one year from $20,000 to $18,000 through use of this Plan, the salary included in your Social Security wage history for that year would be $18,000 rather than $20,000. The exact effect this will have on your Social Security benefits is based on your pay history throughout your working career, your marital status, and other factors. One potential effect is that your Social Security benefits may be reduced.

PREMIUM CONVERSION

This benefit enables you to use before-tax dollars to pay the employee share of the premiums for certain employer-sponsored benefit plans as defined below. If you use this option, your portion of premiums will be deducted from your pay before taxes.

Premium Conversion
You may elect to use Premium Conversion to pay for the cost of the following benefits: Medical, Dental, Vision.

Your share of the cost will be determined annually by the Employer. If there is an increase or decrease in your share of the cost during the plan year, the Employer may on a reasonable and consistent basis automatically make a prospective increase or decrease in your salary reduction contribution.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you elect to participate in the Health Care Flexible Spending Account ("Health FSA"), contributions you designate will be credited to a bookkeeping account on your behalf. This account will be used to reimburse you for eligible health care expenses for you and your eligible dependents that are not reimbursed by insurance.

Eligible Dependents

Eligible dependents are your spouse, qualifying children as described below and other qualifying relatives for whom you provide more than one half of their support.

Qualifying Children
Qualifying children include your natural, adopted, foster and step child, your brother, sister, stepbrother or stepsister and any descendent of these who: 1.) live with you for more than half of the calendar year, 2.) are less than age 19 as of the end of the calendar year (less than 24 if a fulltime student) or are permanently and totally disabled, and 3.) do not provide over half of their own support.

Eligible Health Care Expenses

You may use your Health FSA to be reimbursed for most of the "out-of-pocket" expenses you incur for medical care.

Medical expenses that are reimbursed by insurance, insurance premiums, and expenses for long-term care are not eligible. Insurance premiums your spouse pays through his/her employer will not be reimbursed through this account. Expenses for which you are reimbursed through your FSA may not be claimed as deductions for income tax purposes.

Allowable expenses for medical care include:

- Medical and dental expenses which are covered but not paid by insurance (deductible amounts paid before benefits begin and the percentage of charges not covered)
- Vision and hearing expenses including examinations, eyeglasses, contact lenses, laser eye surgery, hearing aids and seeing-eye dog
- Fees paid to doctors, chiropractors and hospitals
- Dental care including orthodontia
- Routine physical examinations, x-rays and lab fees
- Prescribed medicines and drugs including insulin and birth control pills
- Special equipment bought or rented because of a physical problem (wheelchairs, crutches, etc.)
- Ambulance service and other transportation costs necessary to receive medical care.

Health FSA Limits

The amount available for reimbursement is limited to the amount that you designated as your contribution for the Plan Year and is *not* limited to contributions that have been made to your FSA at the time of reimbursement.

Maximum Election

You can allocate any amount you wish up to a maximum of $2,700 indexed for inflation and adjusted annually. This amount will be communicated by your Employer each year at open enrollment.

Termination of Employment and Leave of Absence

If your employment terminates or you take an unpaid leave of absence, eligible expenses incurred prior to your separation will be reimbursed up to the amount remaining of your annual election. Eligible expenses incurred after your separation will be reimbursed only if you elect to continue contributions and benefits. Your rights to legally mandated continuation coverage are described in the COBRA Continuation Notice found in the next section. If you elect to continue benefits, you must make the required payments in a timely manner.

Health FSA Continuation Coverage is available only if the amount of required payments for the remainder of the Plan Year does not exceed the maximum amount available to the Participant or Qualified Beneficiary for reimbursement for the Plan Year.

Qualified Reservist Distributions are available to individuals who are called to active duty in the military for a period of more than 179 days or an indefinite period. This distribution must be after the date of the order before the end of the claim run-out period for the Plan Year. The amount of the distribution will be based on the amount contributed year-to-date less paid claims as of the date of the request.

If you take an unpaid leave of absence under the provisions of the Family and Medical Leave Act ("FMLA") and do not return to employment following the end of the leave, your coverage will terminate at the end of the FMLA leave. At that time, you may have the right to continue benefits as described in the following COBRA Continuation Notice. If your leave of absence is due to a period of duty in the Uniformed Services of the United States and lasts more than 31 days, you may also continue this coverage.

COBRA Continuation Notice

This Notice contains important information about your right to COBRA Continuation coverage, which is a temporary extension of coverage under the Health FSA benefit. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered by a Health FSA when you would otherwise lose Health FSA coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Health FSA benefit and under federal law, you should either review this Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator. The Plan Administrator is named in the General Information page of this Summary Plan Description.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Health FSA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are

listed later in this Notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Health FSA because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your Health FSA coverage because either one of the following qualifying events happens:

1. Your hours of employment are reduced below the level required for eligibility under the Plan, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your Health FSA coverage because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced below the level required for eligibility under the Plan;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Health FSA because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced below the level required for eligibility under the Plan;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Health FSA as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

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 must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator at the address listed in the General Information page of this Summary Plan Description.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that health FSA coverage would otherwise have been lost.

COBRA continuation coverage for the Health FSA is a limited and temporary continuation of coverage. You will have the right to continue coverage until the end of the plan year in which your termination of coverage occurred.

The monthly cost for continuation coverage may not exceed one-twelfth of your election to the Health FSA plus a two percent administrative surcharge. For example, if you elected $600, your monthly continuation cost would be $51.00 [(600/12) x 1.02]. The Plan Administrator will provide you with the appropriate cost information if you become eligible for continuation coverage.

If You Have Questions
If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan 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.

You may also have rights under state law to continuation coverage under medical, dental and group term life insurance plans offered by the Employer, if any. Please see the medical, dental and group term life insurance plan Summary Plan Description(s) for more detailed information.

Notice of Privacy Practices

This Notice describes how medical information may be used or disclosed, and how you can get access to this information. This Notice applies to the Health FSA and does not apply to any other benefits provided under the Flexible Benefit Plan. The Plan is required to maintain the privacy of your protected health information (PHI) and to provide you with this Notice about its legal duties and privacy practices. The Plan Sponsor, Plan Administrator and third party providers understand the sensitivity of privacy issues and recognize that protecting the privacy and security of your PHI is an important responsibility.

Protected Health Information ("PHI") includes a combination of:

- Medical information about you and
- Individually identifiable information such as your name, address, phone number and social security number (or other identification number).

The Plan Administrator will follow the privacy practices described in this Notice, although the Plan Administrator and Plan Sponsor reserve the right to change the privacy practices and the terms of this Notice. If the practices or terms are changed, a new Notice will be provided to Health FSA participants prior to making a significant change. These changes apply to all information, including PHI created or received before the Notice is changed.

PHI Safeguards
The Plan Administrator is committed to maintaining the security and confidentiality of information received from you relating to the Health FSA. Physical, electronic, and procedural safeguards will be maintained that comply with Federal laws to protect information against unauthorized access and use.

The Plan's Privacy Officer has the overall responsibility of implementing and enforcing policies and procedures to safeguard your PHI against inappropriate access, use, and disclosure. Information on the Privacy Officer is contained on the General Information page of this Summary Plan Description.

Permitted Uses and Disclosures of PHI
PHI can be used or disclosed in a number of different ways. The following are only a few of the types of uses and disclosures of your PHI that are permitted by law to be made without your authorization:

Payment – PHI will be used and disclosed to administer your Health FSA which may involve determination of:

- Eligibility

- Reimbursement
- Utilization review and management
- Medical necessity review
- Coordination of care benefits and other services, and
- Responding to complaints, appeals and external review requests.

PHI may also be used and disclosed for purposes of obtaining premiums, underwriting, rate-making and determining cost sharing amounts. However, genetic testing PHI will not be used.

Health Care Operations – PHI may be used and disclosed to perform the Health FSA's functions as a health plan. This may include:

- Health improvement or health care cost reduction through population-based programs
- Competence and qualification review of healthcare professionals
- Fraud and abuse detection, and compliance programs
- Quality assessment and improvement activities assessment, health claims analysis, and health services outreach
- Case management, disease management, and care coordination services.

PHI may also be disclosed to affiliates and third party "business associates" that perform payment or health care operations activities for the Health FSA on your behalf.

In addition, the law permits use or disclosure of your PHI in the following situations without your authorization:

Required by Law – PHI may be used or disclosed to the extent that required by Federal law.

Public Health – PHI may be disclosed to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as disease, injury or disability.

Abuse or Neglect – PHI may be disclosed to government authorities concerning abuse, neglect or domestic violence.

Health Oversight – PHI may be disclosed to a government agency authorized to oversee the healthcare system or government programs, including audits, examinations, investigations, inspections and licensure activity.

Legal Proceedings – PHI may be disclosed in the course of any legal proceeding, in response to an order of a court or administrative judge and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law Enforcement – PHI may be disclosed under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners and Medical Examiners – PHI may be disclosed in certain instances to coroners and medical examiners.

Research – PHI may be disclosed to researchers, provided that certain established measures are taken to protect your privacy.

Threat to Health or Safety – PHI may be disclosed to the extent necessary to avert a serious or immediate threat to your health or safety or to the health or safety of others.

Military Activity and National Security – PHI may be disclosed to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence

activities.

Correctional Institutions – If you are an inmate in a correctional facility, PHI may be disclosed to the correctional facility for certain purposes, including provision of health care to you or the health and safety of you or others.

Workers' Compensation – PHI may be disclosed to the extent required by workers' compensation laws.

Uses and Disclosures that Require Your Written Authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist; make any disclosure of PHI for marketing purposes; or make any disclosure that constitutes a sale of PHI.

Your authorization will also generally be obtained before the Plan will release your PHI to persons not specifically authorized to receive the information under the Privacy Regulations, such as your spouse. When your authorization is required for a release of your PHI, you will also have the right to revoke the authorization at any time.

Your authorization is required for any use or disclosure of PHI that is not described in this notice.

Uses and Disclosures that Require that You Have an Opportunity to Agree or Disagree before the Information is Used or Released.

The Plan can disclose your PHI to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for that care; and you have either agreed to the disclosures or have been given an opportunity to object and have not objected.

Your Rights Concerning Your PHI
You have additional rights with respect to your PHI:

Right to Request Restrictions – You have the right to ask that restrictions be placed on the use or disclosure of your PHI. However, the law does not require that the Plan agree to these restrictions. If the Plan Administrator does agree to a restriction, the Plan may not use or disclose your PHI in violation of that restriction unless it is needed for an emergency.

Confidential Communication – The Plan Administrator will accommodate reasonable requests to communicate with you about your PHI to an alternative location. You must make your request in writing.

Access to PHI – You have the right to receive a copy of PHI about you that is contained in the "designated record set," with some specified exceptions.

A "designated record set" means a group of records that are used by or for us to make decisions about you, including: enrollment, payment, reimbursement and case or medical management records.

You must make your request in writing to access copies of your records, and provide the Plan Administrator with the specific information needed to fulfill your request.

Amendment of PHI – You have the right to ask that any PHI in a "designated record set" be amended. All requests for amendment must be in writing. The Plan Administrator *will not* amend records in the following situations:

- The Plan does not have the records you are requesting be amended.
- The Plan did not create the records that you are requesting be amended.
- The Plan Administrator has determined that the records are accurate and complete.

- The records have been compiled in anticipation of a civil, criminal or administrative action or proceeding.
- The records are covered by the Clinical Laboratory Improvement Act.

All denials will be made in writing. You may respond by filing a written statement of disagreement with the Plan Administrator, and the Plan Administrator would have the right to rebut that statement. The Plan Administrator will respond to a request to amend within 30 days of receipt of a written amendment request.

Accounting of Certain Disclosures – You have the right to an accounting of times when your PHI has been disclosed for any purpose *other than the following*:

- Treatment, payment or healthcare operations as described in this Notice;
- Disclosures that you or your personal representative have authorized; and
- Certain other disclosures, such as disclosures for national security purposes.

All requests for an accounting must be in writing. You must provide the Plan Administrator with the specific information needed to fulfill your request. This accounting requirement applies for 6 years from the date of disclosure, beginning with disclosures occurring after April 14, 2004.

You have the right to be notified in the event that a breach of your unsecured PHI has occurred.

Additional Information
For additional information, questions about this Notice, or if you want another copy, please write or call the Privacy Officer or Plan Administrator. Contact information is contained on the General Information page of this Summary Plan Description.

If you believe that your privacy rights have been violated, or if you disagree with a decision made by the Plan Administrator about access to your PHI, you may either:

- Call or write to the Privacy Officer.

- Notify the Secretary of the U.S. Department of Health and Human Services (HHS). Send your complaint to: Medical Privacy, Compliant Division Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201.

If it is determined that your privacy rights have been violated, the Plan Sponsor will take appropriate disciplinary action against the individual or entity causing the violation.

The Plan Sponsor and Plan Administrator will not use or disclose PHI for employer-related actions or decisions or in connection with any other Plan Sponsor benefit or employee benefit plan. The Plan Sponsor will not take retaliatory action against you if you file a complaint about these privacy practices either with the Plan Sponsor or HHS.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you elect to participate in the Dependent Care Flexible Spending Account ("Dependent Care FSA"), contributions you designate will be credited to a bookkeeping account on your behalf. Expenses for dependent care that are considered employment-related expenses are eligible for reimbursement from your Dependent Care FSA.

Eligible Dependent Care Expenses

Eligible dependent care expenses are those costs that you incur for care of your dependents (i.e. day care) that enable you and your spouse if you are married, to work. If you are married, your spouse must be gainfully employed, a full-time student, or incapable of self-care.

Eligible dependents are:

- your dependent children and other dependent relatives under age 13; or
- your spouse or other dependent relative who is physically or mentally incapable of self-care who lives with you for more than one-half of the calendar year and, in the case of a dependent relative, who does not have income in excess of the exemption amount.

Your eligible dependents may receive care from a babysitter, dependent care center or someone who comes to your home. However, expenses for care of a dependent outside the home are eligible only if the qualifying individual normally spends at least 8 hours per day in your household. If you utilize a care provider which cares for more than six nonresident persons, the care provider must be licensed and comply with all applicable state and local laws.

The types of expenses that are not reimbursable include care that is primarily educational or medical in nature, education at the kindergarten level or higher, the cost of transportation to and from the care facility and *any portion* of the cost for overnight camp. Household service expenses for food, clothing or entertainment (unless they are incidental to care) are not eligible. Also, services provided by your child under age 19 (or someone you can claim as a dependent on your tax return) are not reimbursable.

Dependent Care FSA Limits

Dependent care reimbursements are paid to you on a pre-tax basis (without income tax or FICA withholding). However the tax benefit from these reimbursements is subject to limitations. You will be required to declare on your income tax return the amount of reimbursement, if any, that exceeds certain limits that are imposed by the tax laws. For example, the maximum reimbursement in a *calendar year* is $5,000 or $2,500 if you are married and file a separate return. In addition, your tax-free amount may not be more than whichever of the following limitations apply to you:

- If you are single, your earned income (after salary reduction) for the year the expenses were incurred; or
- If you are married and your spouse is working, your earned income (after salary reduction), or the earned income of your spouse, whichever is less, for the year the expenses were incurred.

For purposes of applying the earned income limit, earned income generally means income from employment (such as wages, salaries, tips, etc.). If you are married and your spouse is either a full-time student or is physically or mentally incapable of caring for himself or herself, you must assume an earned income of no more than $250 in any one month if you have only one qualified dependent, or $500 in any one month if you have more than one qualified dependent.

Maximum Election

You can allocate any amount you wish up to a maximum of $5,000 per Plan Year, subject to the limitations described above.

Termination of Employment

If your employment terminates or you take an unpaid leave of absence, you may submit requests for reimbursement through the end of the Claims Run-out Period described in the ***FSA Accounts and Forfeitures*** section. Eligible dependent care expenses incurred after your separation but before the end of the Plan Year will be reimbursed up to the amount remaining in your FSA.

Dependent Care Tax Credit

In general, the Dependent Care Tax Credit allows you to reduce the amount of federal income taxes you owe by giving you a credit against your tax liability. The amount of the credit is a percent of eligible dependent care expenses. The percentage varies from 20% to 35% depending on your adjusted gross income. The amount of eligible expenses toward which the credit can be applied is limited to the lesser

of: 1) $3,000 for one child ($6,000 for two or more children), or 2) the earned income of the lower earning spouse.

You cannot claim a Federal Dependent Care Tax Credit on your income tax return for dependent care expenses reimbursed from your Dependent Care FSA. Also, amounts reimbursed through your Dependent Care FSA will reduce, dollar for dollar, the maximum expenses available for determining the tax credit.

In certain cases, it may be more advantageous for you to claim a tax credit for your dependent care expenses rather than pay for those expenses through a dependent care reimbursement account. You may want to consult your tax advisor. Following are some very rough "rules of thumb."

- If you are married filing a joint return, do not qualify for the Federal Earned Income Credit and have two or more qualifying dependents, your family adjusted gross income will probably need to exceed $41,000 before the Dependent Care FSA will yield greater tax savings than the tax credit. If you qualify for the Federal Earned Income Credit, the Dependent Care FSA may yield greater tax savings even at lower incomes. Also remember that because the limit on eligible expenses for the tax credit is $6,000 if you have two or more qualifying dependents, many individuals who use the Dependent Care FSA for the full $5,000 will be able to use the tax credit on qualifying expenses in excess of $5,000 (up to the $6,000 limit).

- If you have only one qualifying dependent and your eligible expenses exceed $3,000, or you qualify for the Federal Earned Income Credit, the Dependent Care FSA may yield greater tax savings, even at lower income levels. Eligible dependent care expenses for one dependent are limited to $3,000 for purposes of the tax credit and $5,000 for purposes of the Dependent Care FSA.

Finally, you should be aware that you will be required to report the name, address and tax identification number of your dependent care provider on your tax return if you use either the tax credit or the Dependent Care FSA.

ENROLLMENT AND ADMINISTRATION

Election Process

Each year you will have the opportunity to re-enroll in the Plan. Health and Dependent Care FSA elections do not carry forward from one year to the next. Elections must be in writing on the form provided and received prior to the first day of the period of coverage.

If you are a new employee, you must file an election within 30 days of your hire date or prior to the completion of the ***Waiting Period*** if that is a later date. If you have been on an FMLA Leave or have been absent due to a period in the Uniformed Services, the leave time will count toward your satisfaction of the service requirement. New employees must make elections within 30 days of the satisfaction of the ***Waiting Period*** or they will receive the ***Default Premium Conversion Election***.

Default Premium Conversion Election

A new Eligible Employee who fails to return an enrollment form will be deemed to have elected to participate in the premium conversion plan. Any premiums will be paid on a pre-tax basis.

Eligible Employees who fail to return an enrollment form during the annual open enrollment period will be deemed to have elected continued participation in Premium Conversion, if they previously elected Premium Conversion.

Election Changes

Once an election becomes effective, it stays in effect until the following Plan Year. You **may not** change your election during the Plan Year except under the following circumstances.

1) You may revoke an election and make a new election for the remainder of the Plan Year if a change in status occurs ***and*** the election change satisfies the consistency rule defined below. A new election must be filed within thirty (30) days after the date of the change in status and will be effective on the Status Change date defined below. A change in status means any of the following:

   - *Change in your legal marital status* due to marriage, divorce, death of a spouse, legal separation or annulment.
   - *Change in the number of your dependents* because of birth, adoption, placement for adoption, or death.
   - *Change in the employment status of you or your dependent* such as termination or commencement of employment, strike or lockout, commencement or return from an unpaid leave of absence, change in work site. In addition, if you or your dependent has a change in employment status that affects eligibility under an employer plan, that is a change in status.
   - *Events that cause a dependent to satisfy or cease to satisfy eligibility requirements of an employer plan* such as gain or loss of student status, reaching the limiting age for benefits or any similar circumstance.
   - *Change in residence of you or your dependent.*

   The consistency rule requires that any election change must be due to and correspond with a change in status that affects eligibility for coverage under this plan or another employer's plan. With respect to accident or health plans, a change in status that affects eligibility includes a change in status that results in an increase or decrease in the number of dependents who may benefit from coverage under the plan. The consistency rule requires that coverage be added or dropped only for an individual who has gained or lost eligibility. Further, an election change to cancel coverage for an individual who gains eligibility under another employer plan satisfies the consistency rule only if that individual actually becomes covered under such plan.

2) You may revoke an election under a group health plan and make a new election on a prospective basis that corresponds with the special enrollment rights provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the enrollment of both new and pre-existing dependents.

3) If you take an FMLA Leave, you may revoke an election for group health coverage and make another election for the remaining portion of the period of coverage as may be provided for under the Family and Medical Leave Act.

4) You may change your election with respect to an accident or health plan if you are required to provide coverage for a child due to a court order, judgment or decree resulting from a divorce, legal separation, annulment, or change in legal custody. You may cancel or terminate coverage for the child under the plan if the court order or decree requires your former spouse or another person to provide coverage for the child but only if you or your former spouse or another person subject to the order certifies that such coverage is in fact provided.

5) If you or a dependent becomes enrolled for Medicare or Medicaid benefits (other than coverage limited to benefits for distribution of pediatric vaccines), you may make a corresponding election change to cancel accident or health plan coverage under this Plan for yourself or the dependent.

Conversely, if you or your dependent is not enrolled in an employer-sponsored accident or health option under this Plan because you were enrolled to receive Medicare or Medicaid benefits and later become ineligible for such benefits, you may make a corresponding election change to elect coverage for yourself or your dependent.

6) If there is a change in the cost or coverage of a benefit (excluding the Health FSA), you may revoke your election with respect to that benefit and make a new election for the remainder of the plan year. Changes in cost or coverage include the following:

   - *Automatic changes* - If the cost of a benefit you are purchasing with Premium Conversion increases (or decreases) during the plan year and you are required to make a corresponding change in your election, the Employer may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elections.

   - *Significant cost changes* - If the cost of a benefit option significantly increases or decreases during the plan year, you may make a corresponding prospective election change. You may commence participation in an option that decreases in cost. You may revoke an election for an option that increases in cost and, if another option that provides similar coverage is available under the plan, elect to receive coverage under that option. Cost increase or decrease for this purpose means a change in the amount of the elective contributions required under this plan, and may result from actions taken by you or the Employer. With respect to the dependent care reimbursement only, a dependent care provider who is not your relative may impose a change in cost which permits you to make a new election. In addition, if your dependent care costs change due to an increase or decrease of hours, you may make a corresponding change to your dependent care election.

   - *Significant curtailment of coverage* - If there is a significant curtailment of coverage under a benefit option, you may revoke your election and receive coverage on a prospective basis under another option providing similar coverage. If the curtailment of coverage involves a loss of coverage, you may drop coverage if no other similar benefit option is available under the plan. A significant curtailment with a resulting loss of coverage includes: HMO not available in geographic area of residence, coverage not helpful because lifetime or annual cap has been reached, a substantial decrease in medical care providers in a PPO network or HMO, a hospital dropping out of the plan or network, reduction in benefits for a certain illness or injury for which a participant or family member is currently in a course of treatment, an increase in deductible, co-pay, out-of-pocket cost-sharing limit or any other similar fundamental loss of coverage.

   - *Addition or improvement of a benefit option* - If a new benefit option is added to the plan, or if coverage under an existing option is significantly improved during the plan year, you may revoke your election and elect coverage under the new or improved benefit option on a prospective basis.

   - *Change in coverage under another employer plan* - You may make an election change that is on account of and corresponds with a change made by your dependent or former spouse under another employer plan if: a.) the dependent's or former spouse's election change would be allowed under this plan, or b.) the dependent's or former spouse's employer plan permits an election for a plan year that is different from the plan year for this plan.

   - *Loss of coverage under other group health coverage* - You may add coverage on a prospective basis if you or your dependent loses coverage under a group health plan sponsored by a governmental or educational institution.

7) You may prospectively revoke an election for coverage under a group health plan that is not a health FSA and that provides minimum essential coverage under the following circumstances:

- *Reduction in work hours* - A change in status reduces your expected average work hours to less than 30 hours per week, even if that reduction does not result in the employee ceasing to be eligible under the group health plan. You and any dependents for whom you revoke coverage must enroll in another plan that provides minimum essential coverage with an effective no later than the first day of the second month following the month in which the original coverage was revoked.

- *Enrollment in a Qualified Health Plan* - You enroll in a Qualified Health Plan through a Marketplace during a Special Enrollment Period or during the Marketplace's annual open enrollment period. You and any dependents for whom you revoke coverage must enroll in a Qualified Health Plan with an effective date that is no later than the day after the original coverage is terminated.

Although some of the above events will permit you to revoke or change a Health FSA election, in no case will you be allowed to reduce your Health FSA election below the amount you have already been reimbursed (or have claimed and are awaiting reimbursement) for the Plan Year.

Status Changes
An election made as the result of a status change will be effective on the first day of the payroll period following receipt of the election form by the Plan Administrator. However, an election change made due to a HIPAA special enrollment right will be effective as of the date required by HIPAA.

FSA Accounts and Forfeitures

Each time you are paid, contributions you allocate for Health FSA or Dependent Care FSA are recorded in a health care account or dependent care account on your behalf. Note these accounts are for bookkeeping purposes only; no money is actually held in the accounts.

You may submit claims for a Plan Year through the end of the ***Claims Run-out Period***. *Any balance remaining in your account(s) after the close of the Claims Run-out Period cannot be paid to you or carried forward into the next Plan Year. You should, therefore, carefully anticipate your needs for the year before determining the amount of your election.* These forfeitures will be used to offset the reasonable administrative expenses of the Flexible Benefit Plan.

Claims Run-out Period
You may submit claims for reimbursement from your Health or Dependent Care FSA through April 30th following the end of the Plan Year.

Submitting FSA Claims

In order to be reimbursed, eligible reimbursement account expenses must have been incurred while you are a participant in the FSA. Expenses are considered incurred on the date the services were provided. You may not receive advance reimbursement for future or projected expenses. Eligible health care claims will be reimbursed up to the full amount of your election, reduced by previously paid claims. Eligible dependent care claims will be reimbursed up to the balance in your Dependent Care FSA at the time reimbursement is requested.

You request reimbursement from your FSA by submitting a claim form and documentation showing the amount, date the expense was incurred, nature of the expense and the name of the provider. You must include bills, invoices, receipts, or other statements from an independent third party verifying expenses. In addition, you must certify that the expense has not been reimbursed and that you will not seek reimbursement under any other plan. To be reimbursed for health care expenses, if the

expense is covered by medical insurance, you must first submit the expenses to your insurance company to obtain whatever reimbursement is available from that source.

The Claims Administrator will make a determination on claims submitted for reimbursement within 30 days of receipt unless a determination cannot be made due to reasons beyond the control of the Claims Administrator. In this case a 15-day extension is available if you are notified of the extension within the initial 30-day period. If a determination on a claim cannot be made because you did not provide sufficient information, you have 45 days from receipt of a request to provide the required information.

Requests for reimbursement may be submitted through the end of the ***Claims Run-out Period***. You will be reimbursed directly. Your Employer does not guarantee that the amounts reimbursed through your Health or Dependent Care FSA will be excludable from gross income for federal or state income tax purposes. It is your responsibility to determine whether or not each payment you receive is a qualified excludable expense. You may wish to consult a tax advisor for assistance.

Using the ThrivePass Benefits Card for the Health FSA

This section applies only to claims you pay using your ThrivePass Benefits Card. You will automatically receive a card when you enroll in the Health FSA. You can use the card to pay for *eligible prescription expenses*. Using the card automatically pays your claim and reduces the amount available in your Health FSA. Note that claim amounts must be less than or equal to your Health FSA balance. Claims in excess of your Health FSA balance will be denied and must be submitted using a claim form and appropriate documentation. To avoid this situation, ask the provider to submit the transaction for the amount of your account balance and pay for the remainder yourself. For example, if you have an expense for $300 and your Health FSA balance is only $200, the provider should submit a transaction for $200 and you should pay the additional $100 with cash or a check.

You cannot use your card to pay for expenses that are reimbursable from another health plan. This information is printed on your card, and each time you use the card you are certifying that you believe the claim is eligible for reimbursement and that it has not been reimbursed from another source and you will not seek reimbursement from any other source. By using the card, you also agree to obtain and keep sufficient documentation to verify the claim in case documentation is needed at a later date.

You can only use your card to pay for prescription expenses, and from certain types of providers such as pharmacies and mass-merchandisers like Target or Wal-Mart. The provider must be assigned an eligible "Merchant Category Code" by the Claim Administrator's electronic payment processing system in order for the card's electronic interface to work. As with non-debit card claims, the claim must be incurred by you or eligible dependent and during a time when you are participating in the Health FSA.

Automatic Payments
When you use your card for expenses at drug stores, pharmacies and mass merchadisers that have implmeneted a compliant Inventory Inforation Approval system (IIAS), your claim is identified as an eligible health care expenses and reimbursed automatically. You do not have to submit additional documentation:

FSA Claim Denial

If you (or your dependent, if any) disagree with the determination of your benefit, you may file a written appeal with the Claims Administrator. The Claims Administrator is responsible for evaluating all benefit claims under the Plan. Accordingly, to obtain benefits, you must complete, sign, and submit to the Claims Administrator a written claim on the Administrator's claim form, available from the Claims Administrator. Failure to utilize or complete the following claims procedures will result in you being barred from asserting the claim in any legal proceeding.

Within 30 days after you file your claim, the Claims Administrator will notify you whether your claim has been upheld or denied. This period may be extended one time for up to 15 days if the Claims Administrator determines that such an extension is necessary and provides an extension notice during

the initial 30 day period. If an extension is necessary, a decision shall be made within 45 days after you file your claim. If you fail to provide sufficient information to determine whether benefits are covered or payable under the Plan, the Claims Administrator will notify you within 30 days after receipt of the claim and you will have at least 45 days to complete the claim.

If the Claims Administrator denies the claim, you will be provided with written or electronic notification of the following:

- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- The specific reasons for the denial;
- The specific reference to the Plan provisions on which the denial is based; and,
- An explanation of the claims review procedure for appeal of the denial.

Within 180 days after you receive notice that your claim has been denied, you or your representative may file a written request to the Claims Administrator to have the Claim Administrator's denial reviewed by a new decision-maker, the Plan Administrator, who is not a subordinate of the initial decision-maker. You are entitled to a new decision on appeal, not simply a review of whether the initial decision was reasonable.

You or your representative may also submit comments, documents, records, and other information after the filing of the appeal that will be considered even if this information was not submitted or considered during the initial decision. You or your representative will be entitled to review a copy of the Plan and any other pertinent documents in the possession of the Employer upon request and free of charge. The Plan Administrator will render a decision upon review of a claim and communicate such decision to you within 60 days of the request.

If the Plan Administrator denies your appeal, you shall be provided with the following information:

- The specific reason or reason for the denial;
- The specific references to the Plan provisions on which the denial is based;
- A statement describing your right to file suit pursuant to ERISA Section 502(a);
- A statement that you are entitled upon request to receive, free of charge, all documents and records relating to your denial; and
- A statement that "You and your Plan may have voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Notwithstanding any statutory limitations period or conflict of law provision to the contrary, no action with respect to any benefit under this Plan may be brought more than six months following the date on which the notice of the adverse benefit determination on review is sent to you.

Unpaid Leave of Absence

If you take an unpaid leave of absence (including an FMLA Leave or USERRA Leave), at your option you may continue any or all of your benefits under the Plan as long as you make the required contributions. You have the option of making contributions in the following ways:

Payment Options During a Leave of Absence

PAY AS YOU GO: You can make pre-tax payments during your leave out of any payments you receive during your leave such as vacation pay, sick pay or wage continuation. If you are not receiving payments during your leave, or if the payments end during the leave, you can make payments directly to the Employer on an after-tax basis. You must make any after-tax payments on or before each pay period during the unpaid portion of your leave, with all delinquent payments to be made within 30 days of their due date.

The Employer may enforce the catch-up Pay On Return option if you fail to make agreed upon pay-as-you go payments, regardless of whether or not an agreement was made in advance of the leave, to the extent permitted by state law.

If your participation in the Plan terminates during an unpaid leave of absence and you return from leave during the same Plan Year, your election for that Plan Year will be automatically reinstated on the same terms and conditions in effect prior to the unpaid leave of absence unless you revoke it in accordance with election change rules described above. However, you will have no greater right to benefits for the remainder of the Plan Year than a Participant who has not taken an unpaid leave of absence. If your coverage under an FSA terminates during an unpaid leave (either because of election revocation or non-payment of premium) you have two options: reinstate the original amount elected prior to the leave, and make up the missed contributions through higher salary reductions for each remaining payroll period during the plan year, or reduce the original election amount by the contributions missed during the leave, maintaining the same level of salary reduction for subsequent payroll periods. In either case, expenses incurred while coverage was not in effect are not reimbursable.

These same options apply if your leave of absence is due to a period of duty in the Uniformed Services of the United States and that duty lasts more than 31 days.

Plan Amendment and Termination

The Flexible Benefit Plan has been designed to comply with all current laws regarding flexible benefit plans. The Employer may change, amend or terminate the Plan, or any portion thereof, at any time. If the Plan is terminated, you will not lose your right to benefits accrued prior to Plan termination.

This Summary Plan Description merely summarizes the benefits provided pursuant to the Plan, and is not the legally controlling document. All determinations regarding benefit entitlement and Plan provisions are based upon the actual Plan documents, which are available for inspection at the office of the Plan Administrator.

GENERAL INFORMATION

Name of Plan: City of Iowa City Flexible Benefit Plan

Plan Sponsor: City of Iowa City
410 East Washington Street
Iowa City, IA 52240

Plan Administrator: City of Iowa City
410 East Washington Street
Iowa City, IA 52240
319-356-5000

Employer Identification Number: 42-6004805

Claims Administrator: ThrivePass
P.O. Box 220
Minneapolis, MN 55440-0220
952-544-8332

Privacy Officer: Personnel Generalist
City of Iowa City
410 East Washington Street
Iowa City, IA 52240
319-356-5000

Plan Number: 505

Type of Plan: The Flexible Benefit Plan is a cafeteria plan under Section 125 of the Internal Revenue Code, allowing a choice between cash and certain qualified benefits.

The Plan is unfunded, with contributions and benefits paid out of the general assets of the Employer and therefore has no trustee.

Plan Year: January 1 through December 31

Funding: FSA benefits are entirely self-funded by the Employer, through salary reduction contributions. The medical, dental and vision insurance coverage purchased through the Premium Conversion option of this Plan is provided through insurance contracts, though the Premium Conversion benefit under this Plan is not insured.

For questions or service of legal process contact the Plan Administrator at:

Attn: Personnel Administrator
City of Iowa City
410 East Washington Street
Iowa City, IA 52240
319-356-5000