



Summary Plan Description

Note to Employer: The United States Department of Labor requires this summary or a copy of it be given to each employee.

Plan Sponsor (Employer), Plan Administrator and Agent for Legal Service

Davy Godfrey
The City of Marietta
205 Lawrence Street NE
Marietta, GA 30060

Employer’s Plan Name: The City of Marietta
Flexible Benefit Plan
Plan Year: 1/1/2023 – 12/31/2023

Plan Administrator accepts service of legal process.

Runout End Date: 3/31/2024
Carryover: \$610.00
Client TASC Id: 4509-8681-4729
Group Name: The City of Marietta

Phone Number: 770-794-5564
Plan Number: 0000220396
Federal Tax Id: 58-6000616

PURPOSE

Your Employer has adopted this Flexible Benefit Plan to allow you to select from among benefit options made available under the Flexible Benefit Plan and pay for the selected benefits for yourself, your spouse, and your dependents via pre-taxed salary reduction contributions. You may choose from these “tax free” benefits in lieu of receiving taxable compensation. The Plan is intended to qualify as a “Cafeteria Plan” within the meaning of Section 125(d) of the Internal Revenue Code, and the benefits you elect will be excluded from your income under Section 125(a).

	Maximum Participant Salary Reduction	Grace Period End Date
Medical (Out-of-Pocket) Expenses (Full and Limited)	\$3050.00*	3/31/2024
Dependent Care Expenses	\$5000.00	3/31/2024

*The listed amount aligns with IRS Health Flexible Spending Account contribution limits.

This Flexible Benefit Plan allows you to reduce your taxable income in direct proportion to (a) your contribution to the cost of your elected benefits and (b) your contribution to any account-based tax advantaged plan or fringe benefit plan offered by your Employer that is governed by the Internal Revenue Service (IRS) Code.

ELIGIBILITY REQUIREMENTS: The benefits offered above are available to the following employees as stipulated below:

Participant Entry Date	60 days after date of hire if hired before 10/01 of the plan year; otherwise, must enroll at open enrollment
Part-time Employees	Excluded
Seasonal Employees	Excluded

This Plan defines a Plan-eligible employee to be an individual classified by the Employer as a full-time or benefited employee who is on the Employer's W-2 payroll. Employees do not include self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

Existing Employees. If you are employed by the Employer on the Plan's effective date, you shall be eligible to participate on the later of the Plan's Effective Date or on the entry date following the date you satisfy the Eligibility Requirements stated above.

New Employees. If your employment begins after the Plan's Effective Date, you will be eligible to participate on the entry date following the date you satisfy the Eligibility Requirement stated above.

Re-employment of Former Employees. A former employee rehired within 30 days of termination will immediately be reinstated into their original elections. A former employee rehired after 30 days of termination must wait until the next open enrollment period to make a new election.

Age Requirement. No maximum age requirement may be imposed for participation in the Plan.

GENERAL INFORMATION

This Flexible Benefit Plan allows you to pay your cost for the benefit plans you elected that are sponsored by your Employer through a Salary Reduction Agreement. This lowers your federal and state taxes. Under this Flexible Benefit Plan two types of benefit plans offered by your Employer may be funded by your salary reduction: premium benefits and reimbursement benefits. Premium benefits are the actual payments made to secure your participation in insurance plans. These are payments made from your Employer's general assets to an insurance company or a third-party administrator. Reimbursement benefits are benefits paid under an agreement to reduce your salary by the amount you elected to defer and pay you tax free benefits for certain qualified medical and dependent care expenses, as authorized under the Internal Revenue Code.

Administration. Your Employer or appointed Plan Administrator is responsible for the administration of your Employer Sponsored General Welfare Plans. Should you need to see any records or have any questions regarding these Plans, contact the Plan Administrator. The Plan Administrator has sole discretionary authority (a) to interpret the Plan in order to make eligibility and benefit determinations, and (b) to make factual determinations as to whether any individual is eligible and entitled to receive any benefits under the Plan. A health insurance issuer is not responsible for the Plan's administration (including payment of claims).

The Plan Administrator appoints TASC as a Service Provider to maintain certain Plan records and to be responsible for the Plan's day-to-day administration. TASC is not a Plan Administrator and has no discretionary authority regarding the Plan.

Plan Termination or Amendment. The Employer, or appointed Plan Administrator, has the right, in its sole discretion, to terminate the Plan or to modify or amend any provision of the Plan at any time. Upon the termination or partial termination of the Plan, Participants have no Plan benefits except with respect to covered events giving rise to benefits occurring prior to the date of Plan termination or partial termination, except as otherwise expressly provided in writing by the Employer.

Excess Payments. Upon any benefit payment made to a Participant in error under the Plan, said Participant will be informed and required to repay the errant amount. This includes and is not limited to amounts over the Participant's annual election, amounts for services that are determined to be ineligible, or when adequate documentation to substantiate a paid claim upon request is not provided. The Employer may take reasonable steps to recoup such an amount including withholding the amount from future salary or wages, and subtracting from future benefit reimbursement(s) the amount paid in error.

No Continued Employment. No provisions either of the Plan or of this Summary shall grant any employee any rights of continued employment with the Employer or shall in any way prohibit changes in the terms of employment of any employee covered by the Plan.

Non-Assignment Of Benefits. No Participant or beneficiary may transfer, assign or pledge any Plan benefits except as may be required pursuant to (a) a “Qualified Medical Child Support Order” (which provides for Plan coverage for an alternate recipient), (b) other applicable law, or (c) electronic payment made directly to a healthcare provider,.

CONTRIBUTIONS AND ENROLLMENT

Participant Contributions. By participating in the Plan, you agree to have your annual compensation reduced by the total cost of the Plan benefits you elected.

Employer Contributions and Enrollment Elections. At its election, your Employer may pay part of the insurance premiums or other qualified benefits made available through this Plan. The annual enrollment materials will include: (1) the amount of any Employer contributions for the various Plans offered by the Employer that allow you to make pre-tax contributions, (2) the rules defining how the Employer contributions may be used, and (3) the enrollment procedures to make annual elections for your pretax contributions. These enrollment materials are incorporated in this Summary Plan Description by reference.

The various benefit plans offered by your Employer may operate under different plan years. For instance, an Employer may enter into an annual contract with an insurance company (to provide benefits to employees) under a contract year that differs from the Plan Year established for this Flexible Benefit Plan. If this is the case, different Plan benefit entry dates will apply.

If you are not eligible to participate in this Plan but are allowed to participate in another benefit plan offered by your Employer, under the eligibility terms of that Plan, your costs will be paid with taxable income, and your compensation will not be reduced by the Employer.

The Health Benefit Waiver

Employees may choose to waive health and dental insurance coverage under the City’s health and dental insurance plan, and instead receive up to \$500 per year from the City. This amount will be deposited into the Flexible Benefits Reimbursement account in the employee’s name to help pay for qualified out of pocket medical expenses incurred by the employee or family members. In order to qualify to participate in this plan, the employee must have health insurance coverage from a provider other than the City and complete an affidavit. The City will match your personal contribution into the Flexible Benefits Reimbursement account up to \$500. If you do not choose to contribute to the Flexible Benefits Reimbursement account, there will be no match from the City.

BENEFITS AND QUALIFYING CHANGE IN STATUS EVENTS

Participants may change their contribution amount or cease participation throughout the plan year. In order for the participant to decrease their contribution, or cease participation, the contributions to date must have surpassed the disbursements to date. If you experience a qualifying change in status, the election change requested must be on account of and consistent with the qualifying event. Any request to change your election must be submitted in writing. The new benefit elections may start only after your change in status has taken place and the new paperwork has been filed.

A qualifying change in status event may be one of the following:

- A change in legal marital status (marriage, death of spouse, divorce, legal separation and annulment).

- The adoption, birth, or death of a child or dependent.

- Dependent satisfies or ceases to satisfy dependent eligibility requirements.

- The change in employment status of you, your spouse or dependent.

- Change in your residence.*

- Beginning or ending adoption proceedings.

- Automatic changes upon cost increases or decreases.*

- Significant cost increases.*

- Significant curtailment of coverage.*

- Addition or elimination of similar benefits package option.*

- Change in coverage of a spouse or dependent under an employer plan.*

- FMLA.

HIPAA special enrollment rights.
COBRA qualifying event.
Loss of group health coverage sponsored by governmental or education institution.*
A judgment, decree or order requiring coverage for a spouse or child.
Medicare or Medicaid entitlement.
Termination of Medicaid or SCHIP** coverage.
Eligibility for Employment Assistance under Medicaid or SCHIP**.
Exchange Event – a loss of eligibility under the terms of the plan due to a reduction in hours (less than 30) – even when the
Employer allows the coverage to continue in effect during the ‘Stabilization Period’ to satisfy the
Affordable Care Act
coverage requirements.*
Exchange Event – Exchange enrollment during an Exchange open enrollment period or special enrollment
period.*

* These qualifying events do not apply to the Medical Expenses Reimbursement Plan.

** State Children's Health Insurance Program.

If you are making tax free contributions to a Health Savings Account (HSA), HealthCare Savings Account (HCFSAs), or Dependent Care Savings Account (DCFSAs) under this Plan, you do not need a ‘change in status’ event to change your HSA election. You may prospectively change your HSA election at any time during the Plan Year.

Under the qualifying events of Termination of Medicaid or SCHIP coverage and eligibility for employment assistance under Medicaid or SCHIP, the employee must request the group health benefit change no later than 60 days after the date of termination or after the date eligibility is determined under Medicaid or SCHIP.

THE REIMBURSEMENT PLANS

If the BENEFITS OFFERED TO EMPLOYEES Section of this Summary Plan Description lists Medical (Out-of-Pocket) Expenses, Dependent Care Expenses and/or Non-Employer Sponsored Premiums, then your Plan includes that Reimbursement Plan.

The Participant Reference Guide, incorporated by express reference into this Summary Plan Description, includes all of the information you need to access your reimbursement accounts and submit claims for reimbursement. By visiting the Account Manager link addressed in this Guide you may access information about your reenrollment, your available funds, annual election, total contributions, and total reimbursements. These plans provide tax free benefits for medical, dependent daycare and/or non-employer sponsored health insurance premium claim reimbursements in accordance with IRS guidelines and protocols.

Medical (Out-of-Pocket) Expenses Reimbursement Plan. All medical claim expenses must be (a) for medical care as defined in Code Section 213(d) which is rendered or received during the Plan Year, with certain limitations described under Services Not Covered; (b) incurred by an employee who has made a valid pre-tax election to participate in the Plan, such employee's spouse, or tax dependent for healthcare purposes as defined in Section 105 (b), (c) not otherwise taken as a medical deduction by a taxpayer and (d) not covered under any other benefit program.

If you contribute to a Health Savings Account (HSA) then you may additionally enroll in a limited *Medical Expenses Reimbursement Plan* only. Qualified expenses under a limited Medical Expenses Reimbursement Plan are limited to dental and vision services or supplies excluded from coverage under your high deductible health plan. The limited Medical Expenses Reimbursement Plan will not provide reimbursement for any other service or supply regardless of whether that service or supply is allowed by the IRS as a medical expense, or allowed under a full Medical Expenses Reimbursement Plan.

Dependent Care Expenses Reimbursement Plan. This Plan provides employees with tax free dependent care assistance only when the assistance is necessary for the Participant to leave the home to engage in activity directly related to his/her employment. The dependent care FSA plan will accept reimbursements for dependent children up to age 14. Qualified expenses under the Dependent Care Expenses Reimbursement Plan include any expenses that you could take as a credit against tax on your income tax form for the care of a Qualified Person. Benefits are provided only to the extent of your payroll deduction on the date the claim is processed. The tax laws further limit how much you may contribute to this Plan. Under the law and the terms of the Plan, you may defer no more than the lesser of your actual (or, if you are married and if less, your spouse's) income for the year or \$5000 per year to this Program. A married Participant who files separate tax returns is limited to \$2500 per year.

HEALTH SAVINGS ACCOUNT (HSA)

If you elect Medical Expenses Reimbursement benefits, you cannot also elect HSA benefits (or otherwise make contributions to an HSA) unless you elect the Limited (Vision/Dental) Medical Expenses Reimbursement Benefit. In addition, when the Medical Expenses Reimbursement Benefit includes a grace period and you have a Medical Expenses Reimbursement Benefit that is not a Limited Benefit, you cannot elect HSA benefits or make contributions to an HSA until the first day of the month following the last day of the grace period, unless the balance in your Medical Expenses Reimbursement Benefit is \$0 as of the last day of that Plan Year.

QUALIFIED RESERVIST DISTRIBUTION

A Participant who is called to active duty in the US Armed Services and enrolled in the Medical Expenses Reimbursement Plan may elect to receive a Qualified Reservist Distribution of all or a portion of the unused balance in his/her individual Medical Expenses Reimbursement Plan subject to the requirements of Code Section 125(h) and the applicable regulations thereunder. The Employer may limit this distribution to the amount you have contributed to the Plan that has not been used to reimburse you for claims submitted.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will provide benefits in accordance with a QMCSO and adhere to the terms of any judgment, decree, or court order which (1) relates to the provision of child support related to health benefits for a child of a Participant in a group health plan; (2) is made pursuant to a state domestic relations law; and (3) which creates or recognizes the right of an alternate recipient—or assigns to an alternate recipient the right—to receive benefits under the group health plan under which a Participant or other beneficiary is entitled to receive benefits. Participants may obtain, without charge, a copy of the Plan's procedures from the Plan Administrator.

LEAVE OF ABSENCE

Family and Medical Leave Act (FMLA). If you go on a qualifying leave under the federal Family and Medical Leave Act (FMLA), to the extent required by the FMLA, your Employer will continue to maintain your benefit package options providing health coverage (including the Medical Expenses Reimbursement Plan) on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contribution to the extent you opt to continue coverage). Your Employer may require you to continue coverage while you are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave.

If your coverage ceases while on FMLA leave, you will be permitted to re-enter the Plan upon return from such leave, and to participate in the Plan on the same basis as you had been prior to the leave or as otherwise required by the FMLA. You may elect reinstatement in the Plan at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a reduced pro-rata coverage level for the period of FMLA leave during which you did not make contributions. Your coverage may be automatically reinstated as well, but only if coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

Unpaid FMLA Leave. If you are going on unpaid FMLA leave and you opt to continue your Medical and Dental Insurance Benefits and Health FSA Benefits, then you may pay your share of the contributions in one of three ways:

- (1) Prepay. Your share of contributions due during your leave may be paid either pre-tax or after-tax before your leave begins provided any pre-tax pre-payments do not fund coverage for the next Plan Year.
- (2) Pay-as-you-go. Your share of contributions will be paid on the same schedule as if you were not on leave or under another schedule. Per the Department of Labor regulations, if you fail to make payments under this option, your Employer is not required to continue coverage. If your Employer chooses to make payment and thereby continue coverage, your Employer is entitled to recoup these amounts from you after you return from leave.
- (3) Catch-up. Your Employer may advance your share of contributions while you are on leave. Upon your return from leave, your Employer may recover the advanced amounts on either a pre-tax or after-tax basis. Check with your Employer to determine if this option is available under your Plan.

Non-FMLA Leave. If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that affects eligibility, then the Change in Status rules will apply.

Military Leave. If you take a leave of absence due to military service, you may continue coverage under this Plan as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

TERMINATION OF PARTICIPATION

Participants are enrolled in the Plan for the entire Plan Year or the portion of the Plan Year remaining after enrollment. You will automatically cease to be a Participant on the earliest of the following dates:

- a. Your death, resignation or termination of employment with the Employer;
- b. The date the Plan terminates;
- c. The date on which you fail to pay any required premium (including payment by salary reduction) under the Plan;
- d. The date you no longer meet the requirements for eligibility in the Plan; or,
- e. The date you revoke your election.

Participants who ceased or will cease their participation in the health FSA, may still incur expenses and receive reimbursements from unused contributions through the end of the plan year in which participation ceased (including the grace period).

Positive Balance: Upon termination your annual election amount will be limited to the greater of the amount paid for coverage (total contributions) less previously paid reimbursements or the total of paid reimbursements from the Plan.

As a terminated participant, you are not eligible for the Grace Period unless your eligibility end date is the same as the last day of the Plan Year.

As a terminated Participant, you are not eligible for carryover.

When your participation has terminated, you may submit eligible claims for reimbursement through your run out end date as noted in the Claims Procedure section of this document.

CLAIMS PROCEDURE

If you have elected reimbursement coverage, active Participants may submit eligible claims for reimbursement through the plan's runout period. The Plan's runout period end date 12/31/2023.

All other claim procedures for the Plan are provided in a separate administrative document upon the original enrollment in the Plan. An additional copy may be provided without charge upon request.

CLAIM DENIALS

Medical and Dental Insurance Benefits. The applicable insurance company will determine your claim in accordance with its claims procedures.

Claims Under the Medical (Out-of-Pocket) Expenses, Dependent Care Expenses or Non-Employer Sponsored Premiums Reimbursement Benefits. The claims procedure described below will apply if (a) a claim for reimbursement under the Medical (Out-of-Pocket) Expenses, Dependent Care Expenses or Non-Employer Sponsored Premium components of the salary reduction plan is wholly or partially denied, or (b) you are denied a benefit under the salary reduction plan due to an issue germane to your coverage under the Plan.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete.) The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected. When a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will effectively suspend the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will detail:

- specific reason(s) for the denial;
- specific Plan provision(s) on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose both the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal. The address to use when filing an appeal will be included in the benefit or enrollment denial letter.

Decision on Review. Your appeal will be reviewed and determination made within a reasonable time, defined as not later than 60 days after receipt of your appeal. If the decision on review affirms the initial denial of your claim, you will be furnished with a Notice of Adverse Benefits Determination on Review, which shall set forth the following:

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

NOTICES REQUIRED BY LAW

Special Rights on Childbirth. Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for (either mother or newborn child) to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section. However, Federal law generally does not

prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above period. In any case, under Federal law a provider may not be required (by Plan or insurer) to obtain authorization from the plan for prescribing a length of stay up to 48 hours (or 96 hours).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") continuation shall not apply to any group health plan of the Employer for any calendar year if all employers maintaining such plan normally employed fewer than twenty (20) Employees on a typical business day during the preceding calendar year. Government entities are subject to the same continuation coverage under the Public Health Services Act. This Summary Plan Description describes your rights for the Medical Reimbursement Plan. Your rights under any of the other Qualified Benefits Plans offered by your Employer are described in the Summary Plan Description(s) for that Plan and may be obtained from your Plan Administrator.

If you elect to participate under the Medical Expenses Reimbursement Plan and are considered a Participant on the day before experiencing a qualifying event, COBRA continuation ends on the last day of the Plan Year in which the qualifying event occurred. Further, COBRA continuation coverage will not be offered if on the day of your qualifying event, the amount of your annual election less any reimbursed claims is less than the amount of premium required to continue the Medical Expenses Reimbursement Plan until the end of the Plan Year. COBRA continuation under an excepted Medical Expenses Reimbursement Plan is available until the end of the Plan Year in which the qualifying event occurs.

A Participant who experiences a qualifying event is considered a qualified beneficiary. When a qualified beneficiary experiences a qualifying event, they will be sent a notification explaining their rights to elect COBRA continuation coverage. Your Employer has 44 days from the date of the loss of coverage in which to send the COBRA Election Notice. A qualified beneficiary who wishes to continue coverage must notify the Plan Administrator of their desire to continue coverage within sixty days of either the date of notification or date of loss of coverage, whichever is later. If the Plan Administrator does not receive notification within this time period, you will lose your right to elect continuation coverage. Finally, qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date that termination from the Plan would have occurred.

COBRA continuation is available until the end of the Plan Year in which the qualifying event occurs. The premium charged for the continuation coverage will be 102% of your monthly contribution. The Employer may require the COBRA payments be apportioned for the remainder of the Plan Year.

Listed below are qualifying events.

- (1) Termination of employment (for reason other than "gross misconduct"); and
- (2) Reduction of employee's work hours.

Questions

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

PLEASE PRINT

NAME: _____
FIRST MI LAST

EMPLOYEE NO: _____ **DEPT:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Attestation of Other Qualifying Health Insurance Coverage

I certify that my dependents and I are covered by another qualifying health plan that conforms to the Affordable Care Act's (ACA) minimum value standard* for Calendar Year 2023. I certify that I will maintain coverage in a qualified health plan on an ongoing basis and I agree to notify the City of Marietta's Benefits Manager within 30 days if I lose coverage under the qualified health insurance plan.

I agree to waive the health insurance and dental premium contribution by the employer and receive a matched contribution of up to \$500 annually into a medical reimbursement account, provided that I also contribute into that account.

I further certify that all information and documentation provided is accurate. I understand that any false, deceptive, or otherwise improper act may result in the cancellation of my participation in this program.

Important Information

This waiver is only effective for the plan year specified and must be renewed on an annual basis during Open Enrollment to continue participation in this program. If you waive coverage during this enrollment, you may later request coverage under the City of Marietta's health plan only if you experience a qualifying family status change or during the annual open enrollment period.

SIGNATURE _____ **DATE** _____

* The Affordable Care Act (ACA) establishes a minimum value standard of the benefits of a health plan. For a qualifying group health plan to meet the ACA's minimum value standards, the plan must cover at least 60 percent of the total allowed cost of benefits provided under the plan. Employees may refer to their plan's Summary of Benefits and Coverage document to determine if their coverage meets the law's minimum value standards.

TERMS AND CONDITIONS

Health Insurance Benefit Waiver - Terms and Conditions

If hired prior to November 1, 2006, the City of Marietta pays 100% of POS health insurance benefit premiums for employees and 80% for employees' covered family members' health insurance benefit premiums. If hired after November 1, 2006, the City/BLW will pay 85% of the single POS premium for employees and 80% for employees' covered family members' health insurance benefit premiums. By my signature, I am electing to waive this health insurance coverage for myself, as employee, and all my covered family members on record as of this date (if any), and choose, instead, the City of Marietta's matched contribution in my name not to exceed \$500 per year into a flexible spending arrangement (FSA) for medical benefits as described below. I am also certifying that my dependents and I are covered by another qualifying health plan that conforms to the Affordable Care Act's (ACA) minimum value standard for Calendar Year 2023.

In order to qualify for this option, I understand that I must comply with all requirements listed below: I must submit a completed Waiver of Employer Coverage Affidavit to the Benefits Manager or his/her designee before I am eligible to participate.

I must notify the Benefits Manager or his/her designee within thirty (30) days of any qualifying event which would affect this agreement. This includes loss of other insurance coverage, which would require both my family, if previously covered, and myself to re-enter the City of Marietta's health insurance program. The City will offer either the same health coverage as is currently being terminated by this agreement, or its equivalent.

Qualifying Event is defined by the IRS regulations as: (1) marriage or divorce of the employee; (2) death of the employee's spouse or dependent; (3) birth or adoption of the employee's child; (4) commencement or termination of employment of the employee's spouse; (5) a switch from part-time to full-time status, or vice versa, by the employee or the employee's spouse; (6) an unpaid leave of absence taken by the employee or the employee's spouse; and (7) a significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

I understand that if I do not notify the City of Marietta Benefits Manager or his/her designee within 30 days of the date of loss of other insurance coverage, I will be required to wait to regain health insurance with the City of Marietta until the next open enrollment period. In all cases, proof of the date of loss of health insurance will be required.

After meeting all of the above qualifications, I understand that in lieu of receiving the City's health insurance benefit for myself or my covered family members (if any), the City of Marietta will match my contribution into a flexible spending arrangement (FSA) in my name up to \$500 per year to be used only for reimbursement of qualified medical expenses (as defined by IRS Code Section 213(d)) which are not paid for by the other insurance coverage.

Examples of reimbursable expenses include, but are not limited to co-pays for doctor visits and prescription drugs, birth control pills, chiropractor expenses, hearing aids, expenses over and above what health insurance will pay for dental work, eye exams, glasses/contact lenses and solutions. Note: Premiums for health insurance are specifically precluded as a reimbursable expense under this plan by the IRS. Visit www.tasconline.com about other qualified medical expenses.