FreedomChoice

GROUP HEALTH PLAN

Summary Plan Description

Medical Expense Reimbursement Plan

As adopted by

City of Abilene

Effective March 1, 2012

Restated January 1, 2018

Third Party Administrative Services by
Freedom Claims Management, Inc.
P.O .Box 1365
2318 N. Washington
Great Bend, KS 67530
(866) 792-9151

FreedomChoice

General Information

1. Introduction

City of Abilene ("Employer") has established a plan for payment of certain expenses for the benefit of its eligible employees. It is named and known as a "Medical Expense Reimbursement Plan" and will be referred to in this document as either the "Plan" or "FreedomChoice."

This FreedomChoice Plan consists of 2 components (which together comprise the Umbrella Policy and FreedomChoice):

A. The Base Plan organized and administered in accordance with Section 105 of the Internal Revenue Code.

a. The Base Plan is embodied by an agreement entitled "FreedomChoice Medical Expense Reimbursement Plan Adoption Agreement".

b. This agreement is a plan document. FreedomChoice is designed to reimburse eligible employees (those that are participating in the Employers Insured Health plan) for a portion of their and their dependents' health claims that count toward the deductible under the Employer Insured Health Plan while they are employed with the Employer and the Plan remains in effect. Please note that it is not necessary that you have actually paid an amount due for Eligible Medical Expense--only that you have incurred the expense, that you have submitted it to the Umbrella Policy health carrier, that it has been processed and reported by them via the Explanation of Benefits ("EOB"), and that it is not being paid for or reimbursed from any other source.

2. Purpose of this Summary Plan Description

This Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it.

3. Conflicts

A. If there is a conflict between the plan documents and this summary, the plan documents will prevail.

B. If there is a conflict between the two plan documents, the Umbrella Policy will prevail.

4. Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and your Employer. Your Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

5. The source of FreedomChoice contributions

Your Employer supplies the funds for FreedomChoice based on actual claims as incurred.

6. Effective date of the Plan

March 1, 2012, Restated January 1, 2018

7. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. Such action shall not deny any employee's right to claim reimbursement for expenses incurred before such amendment or termination. Employer shall give employees written notice of amendment not more than 60 days following such action or within 30 days of termination.

8. Plan Year

Your Umbrella Policy Carrier's records are maintained on a twelve-month period of time. This is known as the Plan Year. The first Plan Year begins on January 1, 2018 and ends on December 31, 2018. In subsequent years, it begins on January 1st and ends on December 31st. Benefits under the Umbrella Policy and the FreedomChoice Plan are paid on a Plan year basis from January 1st through December 31st.

9. Plan Sponsor/employer's name and address

City of Abilene
419 N. Broadway
Abilene, Kansas 67410

10. Plan Sponsor's tax identification number

City of Abilene - 48-6017973

11. Plan Administrator's name, address, and phone number

City of Abilene
419 N. Broadway
Abilene, Kansas 67410
(785) 263-2550

12. Third Party Administrator

Your Employer has contracted with Freedom Claims Management, Inc. ("FCMI"), which is headquartered in Great Bend Kansas, to process the claims on its behalf.

13. Plan number

Your Employer has assigned Plan Number 105 to your Plan.

14. Plan's agent for service of legal process

City of Abilene
419 N. Broadway
Abilene, Kansas 67410

15. No Taxation

The Employer intends that this Plan and all benefits payable under this Plan shall qualify for exclusion from eligible employees' gross income under Internal Revenue Code Sections 105 and 106. The Employer reserves the right to amend or terminate this Plan in the event that such benefits no longer qualify for such exclusion.

16. Who is eligible for medical coverage under FreedomChoice

Any eligible employee of the Employer who is eligible to participate in the Umbrella Policy is eligible to participate in FreedomChoice. Participation in FreedomChoice is automatic upon the employee's Participation in the Umbrella Policy.

17. Does the Plan provide benefits for my family?

The Plan provides reimbursement for eligible medical expenses incurred by you, your spouse, and any dependent, who is covered by the Umbrella Policy.

18. When am I eligible for coverage under FreedomChoice?

Once you are employed by City of Abilene you are then eligible first of the month following date of hire.

19. When must the expenses be incurred for which I may be reimbursed?

An eligible expense must have been incurred during the Plan Year. You may not be reimbursed for any expenses arising before the Plan became effective, before you became covered under the Plan, simultaneous to the time you became covered under the Umbrella Policy, or for any expenses incurred after the close of the Plan Year, or, except for Continuation Coverage, after a separation from service and COBRA continuation coverage has been elected.

20. What is an eligible medical expense?

An eligible medical expense is an expense incurred by the Employee, or the Employee's Dependents, after the date of the Employee's participation in the Umbrella Policy and simultaneously in FreedomChoice and during the Plan Year otherwise allowable as deductions under Code Sec. 213 (without regard to the limitations contained in Sec 213(a)) that are covered expenses.

For purposes of this Plan, an expense is "incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

21. How will my medical expenses be paid under FreedomChoice?

A. The Plan may reimburse you or, more likely, it will make payment directly to your health-care provider.

B. A claim will be processed and paid within 30 days unless additional information is requested.

22. Coordination of Benefits

FreedomChoice shall reimburse the employee only in the event and to the extent that the expenses are not covered by any insurance policy, policies, or benefits, whether owned by Employer or employee, provided under any other accident or health insurance plan, provided by federal or state governments or agencies, or provided by any other source. In the event that such a policy or benefits are in effect, FreedomChoice shall be relieved of any responsibility for expenses covered by the policy, policies, or benefits.

23. Termination of coverage under FreedomChoice

Participation in FreedomChoice shall terminate on the earliest of:

A. The date an Employee ceases to be Employee;

B. When an Employee ceases to meet the eligibility requirements of this Plan (e.g., the Employee loses coverage under the Insured Health Plan by failing to pay any applicable premium);

C. The date this plan is amended to exclude the Employee or is terminated.

24. Does my coverage under this Plan end when my employment terminates?

Yes. Your normal participation will cease at the end of the month in which your employment with the Employer terminates. However, you and your family will have the opportunity to continue to be covered under the Plan under the terms of the Continuation Coverage provisions described below.

25. Circumstances that may result in loss or denial of benefits under FreedomChoice

A statement clearly identifying circumstances that may result in loss or denial of benefits (e.g. subrogation, Coordination of Benefits, and offset provisions)

26. What happens if my claim for benefits is denied?

A. All claims are adjudicated (reviewed for approval under the provisions of FreedomChoice) by FCMI. All amounts due under FreedomChoice are based upon the determination made by FCMI.

B. You will be notified in writing by FCMI via EOB within 30 days of the date you or your health-care provider submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim.

C. If a claim is denied under FreedomChoice but approved under the Umbrella Policy, you will further be advised of your right to request an administrative review of the denial of such claim, and you may request a review any time within the 180-day period after you have received notice that such claim was denied.

D. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

27. What is "Continuation Coverage" and how does it work?

"Continuation Coverage" means your right, or your spouse's and dependents' rights, to continue to be covered under FreedomChoice (and Umbrella Policy) if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." You must also continue coverage under the Umbrella Policy in order to continue benefits hereunder.

A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours.
- Your death.
- Divorce or legal separation from your spouse.
- You become eligible to receive Medicare benefits.
- When a dependent of yours ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs. The notification you will receive will explain all terms and conditions of the continued coverage.

Other Considerations

28. ERISA Statement of Participant Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act ("ERISA").

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the plan, or from exercising your rights under ERISA. If your claim for a benefit under the Plan provisions is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 the Plan Administrator to provide the materials and pay you up to $100 a 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, you may file suit in a state or federal court. If it should happen that the plan's 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. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this Part of the Summary Plan Description or about your rights under ERISA, you should contact the nearest office of the U. S. Labor-Management Services Administration, Department of Labor.

29. Family and Medical Leave *(applicable to groups 50+ employees)*

As an employee of Employer, you may be entitled under the federal Family and Medical Leave Act (FMLA) up to 12 work weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for the Company for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent), FMLA military leave, or a personal serious health condition. As a participant in the Plan, you have while on leave under the FMLA the option to continue your health benefits on the same terms and conditions as immediately prior to your taking FMLA leave.

You and your eligible dependents shall remain covered under this plan while you are on FMLA leave as if you still were at work. Your coverage will be maintained until you return to work or, if earlier, you notify the Company that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before, or at the end of FMLA leave, you and your eligible dependents shall become covered under the health plan the first of the month following your return, without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave. You and your eligible dependents may also be reinstated in the HRA Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA. More details on your FMLA rights and benefits while on FMLA leave should be found in your employer's employee handbook.

30. Uniformed Services Employment and Reemployment Rights Act ***(applicable to any size group)***

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave") may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

31. Non-FMLA and Non-USERRA Leaves of Absence

- **A.** A Participant who goes on a leave of absence that is not subject to FMLA or USERRA will be treated as having terminated participation.
- **B.** A terminated employee, who is rehired and returns to work, will be treated as a new hire and required to satisfy all of the Plan's eligibility and waiting period requirements.

32. Qualified Medical Child Support Orders

Generally, your Plan benefits may not be assigned or alienated.

However, an exception applies in the case of a "qualified medical child support order." A qualified medical child support order is a court-ordered judgment, decree, order or property settlement

agreement in connection with state domestic relations law, which either creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan. A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator when it receives a medical child support order that applies to you, and the Plan's procedures for determining whether the medical child support order is qualified.

33. Definition of "Dependent" Revised by the WFTRA of 2005

The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 effective January 1, 2005. An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

A. The individual is under the age of twenty six (26).

B. The individual is the Employee's own blood descendant of the first degree.

C. The individual is a lawfully adopted Child or a Child placed with a covered Employee in anticipation of adoption.

D. The individual is a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993.

E. The individual is a stepchild.

F. The individual is an eligible foster child which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by the Employer, dependent children may be covered by either spouse, but not by both.

34. Your HIPAA Privacy Rights--Use and Disclosure of Protected Health Information (PHI)

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the Plan from using or disclosing certain health information about you that is created or received by the Plan without your written authorization. For additional information about your privacy rights, please refer to the Plan's Privacy Notice or contact the Plan's Privacy Official. Protected Health Information generally includes all information, whether written or oral, in connection with the Plan that (1) is created or received by the Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you. If you wish to authorize the Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

Permitted Uses and Disclosures

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

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the Plan's Privacy Notice or contact the Plan's Privacy Official.

Disclosures to the Company

After the Company has certified to the Plan that it is in compliance with the Privacy Rule, the Plan may disclose PHI to the Company without your authorization to the extent that the PHI is necessary for the Company to perform Plan administration functions. The Plan may not disclose any more PHI to the Company than is necessary for the Company to fulfill its administration functions, and the Plan may not disclose PHI to the Company for purposes of any employment-related actions or in connection with any other employee benefit provided by the Company.

To the extent that your PHI is disclosed to the Company, the Company will:

- Not use or further disclose PHI other than as permitted or required by the official Plan document or as required by law;
- Ensure that any agents to whom the Company provides PHI (or certain electronic PHI) received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit provided by the Company unless authorized by you;
- Report to the Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available to you in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books, and records relating to the Company's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Company may only disclose your PHI (or certain electronic PHI) to the following Company employees and may only do so to the extent that the Company employees perform Plan administration functions:

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

If a Company employee does not comply with the requirements of the Privacy Rule, then the Company may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.