

City of Marquette

Fixed Contribution Health Reimbursement Arrangement Plan, (Flat HRA)

Plan Document

Amended February 01, 2023

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Plan Purpose

The name of this plan is Fixed Contribution Health Reimbursement Arrangement Plan, established by the employer, City of Marquette, whose address is 300 West Baraga Avenue, Marquette MI 49855. For more information on the Plan Sponsor, see Administrative Facts section. The effective date of this Plan is Sunday, July 01, 2012.

City of Marquette hereby establishes the City of Marquette Fixed Contribution Health Reimbursement Arrangement (HRA) Plan (the Plan) effective, Sunday, July 01, 2012. This Plan is integrated with the City of Marquette High-Deductible Health Coverage Plan (the HDHC Plan) and shall be administered accordingly. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Section I.

The purpose of the Plan is to allow employees of the Employer to pay for medical services not otherwise reimbursed or reimbursable in full by any other accident or health plan and such reimbursements are intended to be eligible for exclusion from participants' gross income under Code §105(b). This plan is intended to be an employer-provided medical reimbursement plan under Code §105 and §106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in IRS Notice 2013-54 and DOL Tech Rel. 2013-3, through integration with the HDHC Plan. This Plan and the HDHC Plan shall be interpreted to accomplish these objectives.

This Fixed Contribution Health Reimbursement Arrangement Plan is replacing the City of Marquette Fixed Contribution Health Reimbursement Plan that was effective February 01, 2010.

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Section I

Definitions

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following shall apply in reading this instrument:

“Affiliated Company” means:

- A. Any corporation which is a member of a controlled group of corporations including those within the meaning of section 1563(a) and 414(b) of the Code, determined without regard to sections 1563(a)(4) and (e)(3)(C), including the Employer;
- B. Any organization under common control with the Employer within the meaning of section 414(c) of the Code;
- C. Any organization which is included with the Employer in an affiliated service group within the meaning of section 414(m) of the Code; or
- D. Any other entity required to be aggregated with the Employer pursuant to regulations under section 414(o) of the Code.

“Benefit Credits” means:

The amounts set-aside for Benefits under Section 3 and credited to the Participant’s Fixed Contribution Health Reimbursement Arrangement account.

“Benefits” means:

The reimbursements for medical care expenses under the Plan, as set forth in this Plan.

“Board” means:

The Marquette City Commission.

“Change in Status” means:

- A. A change in a participant’s legal marital status, including marriage, divorce, legal separation, annulment, or death of the participant’s spouse.
- B. An event affecting the number of the participant’s dependents, including birth, death, adoption, and placement for adoption.
- C. A change in employment status of the participant, his spouse or dependents, including termination or commencement of employment (as determined under the Code Section 125 regulations); a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; or a change in the employment status of the participant, his spouse or dependent (e.g., hourly to salary, union to non-union, or full-time to part-time), that affects that person’s rights under this Plan or an underlying benefit program (e.g., changing from salaried to hourly-paid, union to non-union or part-time from full-time).

- D. An event that causes a participant's dependent to satisfy or cease to satisfy the eligibility requirements for a particular benefit, such as attaining a specified age.
- E. A change in the residence of the participant, his spouse or dependent.
- F. The participant's or dependent's coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage and the participant requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.
- G. The participant or dependent becomes eligible for state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan and the participant requests coverage under the group health plan not later than 60 days after the date the participant or dependent is determined to be eligible for such assistance.
- H. Any other events included under Code Section 125, or regulations or other guidance promulgated there under relating to changes in family status. The determination of whether there is a Change in Status shall be determined by the Plan Administrator in its sole discretion, consistent with the regulations under Code Section 125.

“COBRA” means:

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means:

The Internal Revenue Code of 1986, and the same as may be amended from time to time.

“Committee” means:

The individuals who may be appointed by the Plan Administrator to administer the process of claims review for the Plan in accordance with Section 4.

“Dependent” means:

(a) A dependent as defined in Code §105(b), (b) any child (as defined in Code §152(f)(1)) of the participant who as of the end of the taxable year has not attained age 27, and (c) any child of the participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year). Notwithstanding the foregoing, the Flat HRA Account will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “dependent”.

“Effective Date” means:

Monday, February 01, 2010.

"Electronic Protected Health Information":

Has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means:

Any employee who meets the eligibility requirement set forth: Any full-time employee who is enrolled in the City's HDHC plan and also in the Buy-Down option are eligible for this plan. Active employees enrolled in the modified Buy-Down are not eligible for benefit credits in this plan. Seasonal, temporary, or part-time employees who work less than 30 hours per week are ineligible for this Plan. All employees who have not reached the 1st of the month following their date of hire are ineligible for this Plan. Former employees who have not completed 10 years of service are not allowed in this Plan.

Retired employees who have completed 10 years of service are eligible for the plan but will receive no additional benefit credits to the Fixed Contribution Health Reimbursement Account after the date of retirement. Eligible retired employees may continue to submit expenses to exhaust (see "spend down") their remaining balance as long as they continue to pay their monthly administrative fee associated with the Flat HRA, deducted from their remaining funds on a monthly basis.

Former employees who have completed 10 years of service are eligible for the plan but will receive no additional benefit credits to the Fixed Contribution Health Reimbursement Account after the date of termination. Eligible former employees may continue to submit expenses to exhaust (see "spend down") their remaining balance as long as they continue to pay their monthly administrative fee associated with the Flat HRA, deducted from their remaining funds on a monthly basis.

Active employees who enroll in a plan other than the City's HDHC Plan with the Buy-down option will receive no additional benefit credits to the Fixed Contribution Health Reimbursement Arrangement. Active employees not enrolled in the Buy-down plan who were previously enrolled in the Buy-down plan and have remaining benefit credits, may continue to submit expenses to exhaust (see "spend down") their remaining balance as long as they continue to pay their monthly administrative fee associated with the Flat HRA, deducted from their remaining funds on a monthly basis.

"Eligible Medical Expense":

(See "Expense" below.)

"Employee" means:

An individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period

during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any self-employed individual; (d) any partner in a partnership; (e) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be a more-than-2% shareholder by virtue of the Code §318 ownership attribution rules; (f) independent contractors; (g) elected officials; and (h) seasonal employees who work less than 6 months per year.

“Employer” means:

City of Marquette which succeeds to its business and elects to continue this Plan, which adopts this Plan with the consent of the Board.

"Employment Commencement Date" means:

The first regularly scheduled working day on which the employee first performs an hour of service for the Employer for compensation.

“Enrollment Form” means:

The form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan. The form may be in electronic format.

“Enrollment Period” means:

The period upon becoming an eligible employee. In addition, the Plan Administrator has specified another acceptable enrollment period, which is open enrollment during the month prior to the plan anniversary or upon becoming an eligible employee.

“Entry Date” means:

The first pay-period following eligibility. Additional entry date(s) include(s) first day of month following date of hire.

“Expense” means:

Any amount incurred by a participant or his or her spouse or dependents for medical services, as defined in Code §213 (including, for example, amounts for certain hospital and doctor bills) only to the extent that the participant or other individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the HDHC Plan, other insurance, or any other accident or health plan. If only a portion of a medical care expense has been reimbursed elsewhere (e.g., because the HDHC Plan imposes co-payment or deductible limitations), the Flat HRA Account may reimburse the remaining portion of such expense. A medical care expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical care expenses incurred before a participant first becomes covered by the Plan are not eligible. "Eligible Medical Expenses" shall not include (1) health insurance premiums for individual policies or for any other group health plan (including the HDHC Plan); (2) unprescribed medicines or drugs (other than insulin), without regard

to whether such medicine or drug could be obtained without a prescription. The Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug subject to this rule and whether the requirement of a prescription has been satisfied. Please refer to "Schedule A" for medical care expenses eligible under this plan.

"FMLA" means:

The Family and Medical Leave Act of 1993, as amended.

"HDHC Plan" means:

The City of Marquette High-Deductible Health Coverage Plan.

"Highly Compensated Employee" means:

An individual defined under Code §105(h), as amended, as a "highly compensated individual."

"HIPAA" means:

The Health Insurance Portability and Accountability Act of 1996, which may be modified or amended at any time.

"Key Employee" means:

Any employee defined as such in section 416(i)(1) of the Code.

"Maximum Benefit" means:

The yearly maximum benefit.

"Participant" means:

Any eligible employee who has met the conditions for participation set forth in Section 2, below.

"Participating Employer" means:

The employer and any affiliated company, which adopts this Plan with the consent of the board.

"Plan" means:

The Fixed Contribution Health Reimbursement Arrangement Plan described herein and as amended from time to time.

"Plan Year" means:

The Plan Year will begin Friday, July 01, 2022 and ends Friday, June 30, 2023. The subsequent Plan Year will begin Saturday, July 01, 2023 and each July 1 thereafter.

"Qualified Benefits" means:

Each reimbursement for medical services, as described in the document.

"Qualified Medical Services" means:

Means a medical service that is considered to be medically necessary or prescribed by a licensed practitioner is eligible which was not reimbursed or not reimbursable by any other medical benefit plan, to the extent available to the participant, and includes

only those medical services that are reimbursable by the employer's other plans providing coverage for medical services. If coverage is provided by this plan and under an accident and health plan providing similar benefits, the benefits of this plan must be paid first from this plan until all benefit credits are exhausted, and then from any other available accident and health plan. The eligible medical services must be supported by adequate evidence of the incurring of such and submitted to the employer by the participant or his legal representative. The determination of the qualification of the medical service and the determination of the completeness of submitted request for reimbursement will rest solely on the employer or person or persons appointed to review all claims. The consequent employer's decision will be final.

“Reimbursement” means:

The actual transfer of benefit credits available to a Plan participant in the Flat HRA account, by the Employer, for payment of qualified medical services. The reimbursement will be in the form of a check drawn on the funds of the Employer, or in any other form as determined by the Employer.

“Retirement” means:

The voluntary withdrawal of active employment with the Employer after attaining the minimum retirement age and years of service.

“Spend Down” means:

Allowing active employees with remaining account balances no longer enrolled in the City’s HDHC with Buy-Down plan and retirees or terminated employees with vested accounts, while participating in the Plan, to continue to receive reimbursements from the Plan until their unused account balance has been exhausted. Monthly administrative fees are deducted from remaining funds.

“Spouse” (as used in this Plan) means:

An individual who is treated as a spouse for federal tax purposes.

"Suspension Election Form" means:

The form provided by the Plan Administrator for the purpose of allowing a participant to suspend his or her Flat HRA account for a Plan Year.

“Vested” means:

Unused benefit credits in an Active Employee not enrolled in the City’s HDHC plan with Buy-Down option, a Retiree or a terminated Participant's Flat HRA account qualify for spend down. Retiree or terminated Participants must have completed at least 10 years of employment with the City of Marquette in order to be vested.

Section II

Participation in the Plan

Commencement of Participation

Each eligible employee shall be eligible to become a participant on his entry date.

Procedure for and Effect of Participation

An eligible employee may become a participant in the Plan by executing and submitting a properly completed enrollment form, available from the Employer or Plan Administrator and by providing such data as is reasonably required by the Employer as a condition of such participation. The enrollment form shall identify the spouse and dependents, whose medical care expenses may be submitted to the Flat HRA. The participant must notify the administrator within 30 days if this information changes. Each individual shall for all purposes be deemed conclusively to have consented to the provisions of the Plan and all amendments thereto.

Election to Suspend Flat HRA Account

A participant may elect to suspend his or her Flat HRA account for any future Plan Year by submitting a suspension election Form to the administrator before the beginning of that Plan Year. The participant's suspension election will remain in effect for the entire Plan Year to which it applies, and the participant may not modify or revoke the election during that Plan Year. The participant will not receive reimbursements for any medical care expenses incurred during the Plan Year to which the suspension election applies.

If a participant suspends his or her Flat HRA account for a Plan Year, the Employer will suspend contributions to the Flat HRA Account for that Plan Year. Medical care expenses incurred before the beginning of the suspended Plan Year will be reimbursed during the suspended Plan Year, subject to the reimbursement procedures set forth in this plan, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

Permanent Opt-Out

In lieu of a temporary suspension of a participant's Flat HRA account, a participant may elect to permanently opt out of and waive future reimbursements from his or her Flat HRA Account. A participant who makes that election will not receive reimbursements for any medical care expenses incurred after the opt-out election takes effect. Medical care expenses incurred before the opt-out election takes effect, however, may be reimbursed during the first Plan Year to which the opt-out election applies, subject to the reimbursement procedures set forth in this plan, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

If a participant permanently opts out of this Plan, the Employer will also discontinue contributions to the participant's Flat HRA account and the participant will have no opportunity to resume participation in the current plan year or any future plan years.

The opportunity to make a permanent opt-out election shall be offered to each participant at least annually. No similar offer shall be required at termination of employment because in that case the reimbursements are limited as outlined in Section III, Reimbursements.

Cessation of Participation

A participant will cease to be a participant as of the earlier of:

- A. the date on which the Plan terminates;
- B. the date on which he ceases to be an eligible employee because of a loss of coverage under the HDHC;
- C. the date on which he fails to satisfy any requirement necessary to be an eligible employee other than coverage under the HDHC Plan, provided that an employee's participation may continue for purposes of COBRA coverage, as may be permitted by the administrator on a uniform and consistent basis;
- D. the date on which a Participant on Spend Down has exhausted their balance;
- E. the date on which a participating employer terminates its participation in the Plan.

Once the eligible employee is enrolled as a participant, his or her participation will continue until his or her participation ceases pursuant to the above or the participant elects to suspend or permanently opt-out. If a plan participant fails to complete an election form for the upcoming Plan year, then the participant will be automatically enrolled in the Core for the full Plan year.

Nothing in this section shall prohibit the payment of benefits with respect to claims arising prior to the participant's termination of participation, so long as no suspension election or permanent opt-out was in effect for the Plan Year in which such expenses were incurred.

Change in Enrollment

An eligible employee, who is not enrolled, may complete an enrollment form in connection with a change of status:

When a significant coverage is no longer available resulting in a loss of coverage under this Plan, a participant may change to another benefit option, if available, or cease enrollment.

Participants may make a change in benefit options that corresponds with changes made under an accident and health plan of the spouse's or dependent's employer including changes made under a domestic partner's Plan, or the Plan of the employee's Employer. The change request must be combined with adequate documentation describing the change in coverage for which the participant, dependent, or domestic partner is covered.

Participants may make a change in coverage to add self or dependent that loses coverage under a health plan maintained or administered by a government or educational institution.

Notwithstanding the foregoing, a former participant who continues to receive compensation from the Employer shall remain a participant for all purposes until such compensation ceases.

Section III

Benefits

Benefit Credits

There shall be credited to each participant's Flat HRA account those benefit credits that correspond to the amount of the Employer's funding for the complete Plan Year or for such partial Plan Year, as shown by the amounts set forth on Schedule A attached hereto, and as may be revised by the Employer from time to time. The amount of benefits actually provided to or for the benefit of any participant shall be a charge to the balance of his Flat HRA account.

Election of Benefits

A participant will select between the three optional benefit Plan tiers of coverage: a.) Single employee only, b.) Two Person c.) Family benefits. Selection of the proper option will be completed on the enrollment form.

Coordination of Benefits

The Flat HRA may only pay eligible medical expenses not previously reimbursed or for which you will not seek reimbursement from any other accident or health plan, cafeteria plan, or health insurance. If an eligible medical expense is payable or reimbursable from another source, that other source must pay or reimburse prior to payment or reimbursement from the Flat HRA. If only a portion of an eligible medical expense is reimbursable by another health plan (e.g., because of copayment or deductible requirements), the Flat HRA can reimburse the remaining portion of the expense if it otherwise meets the requirements of the Flat HRA. However, if eligible medical expenses are covered by both Flat HRA and by a health flexible spending account (health FSA), the Flat HRA will pay first, exhausting all available Flat HRA Credits, before the health FSA may provide reimbursement.

Nature of Participant Fixed Contribution Health Reimbursement Arrangement account

No money shall actually be allocated to any reimbursement account; any such reimbursement account shall be of a memorandum nature, maintained by the Plan Administrator for accounting purposes, and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to a Flat HRA account.

Provision of Benefits

The employer shall provide such benefits as the participant has elected under the Plan, in such amounts as do not exceed the amount indicated on the Schedule A of this Plan, and subject to employer contributions from time to time. Such benefits shall be subject to the provisions of this Plan, the Summary Plan Description, contract, or other arrangement setting forth the further terms and conditions pursuant to which such benefits are provided. No amount shall be applied to provide benefits under this Plan if such amount would exceed the balance of the participant's benefit credits in the Flat HRA account.

Contributions

Your Flat HRA account will be credited pro-rata each bi-weekly pay period with an amount equal to the applicable maximum dollar limit for the period of coverage divided by the number of weeks in that period of coverage. Benefits shall be available during the period of coverage based on the accumulated account balance as credited each pay period, increased by any carryover of unused Flat HRA account balance from a prior period(s) of coverage.

Qualified Expenses

Means the medical expenses incurred during the period of coverage by you, spouse, or your eligible dependents while you remain a participant. For purposes of the Plan, an expense is incurred on the date when the underlying service(s) giving rise to the medical expense(s) is/are performed and not on the date that the service(s) is/are billed by the service- provider or paid by the participant.

Reimbursement of Medicines and Drugs Sold Lawfully Without a Prescription

Notwithstanding any other provisions in the Plan to the contrary, medicines or drugs that are sold lawfully without a prescription need not be prescribed to qualify as Medical Care Expenses reimbursable under the Plan's Health FSA Component if the expenses for these items are incurred on or after January 1, 2020. In addition, expenses for menstrual care products incurred by a Participant or his or her Spouse or Dependents on or after January 1, 2020, shall qualify as Medical Care Expenses. For this purpose, menstrual care product means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation or other genital-tract secretions.

Reimbursement Rate

The Plan reimburses at a rate of 100% for each qualified medical expense that is incurred.

Available Amount

The amount available for reimbursement of qualified expenses is the amount credited to the participant's Flat HRA account reduced by prior reimbursements.

Eligible Retired Employees

Eligible retired employees will receive no additional benefit credits to the Flat HRA account after the date of retirement. Eligible retired employees will be allowed to continue to submit expenses to exhaust their remaining balance provided they have completed 10 years of employment with the City of Marquette. The retiree will be responsible for paying the monthly administration fee associated with their Flat HRA.

Unqualified Expenses

Health insurance premiums for any other plan (including a plan sponsored by the Employer). (Notwithstanding the forgoing, the Flat HRA Account may reimburse COBRA premiums that a participant pays on an after-tax basis under any other group health plan sponsored by the Employer).

Carryover of Accounts

If the employee who has been a participant in the Plan, enrolls in a different Employer health plan during open enrollment that does not have a Flat HRA account, the employee will have two options for any remaining balance in his account for the remainder of the Plan Year. The employee may elect to suspend his balance for the Plan Year (see Section 2 – Election to Suspend Account) or he may continue to spend down the balance in his Flat HRA as long as the proper application and authorization to deduct administrative fees is completed. This authorization will be valid for the remainder of the Plan Year or until the balance in the account is exhausted, whichever occurs first.

Additional Benefits

If at the end of any Plan Year where there remains any unused benefit credits to the participant's Flat HRA account, and the participation of the participant continues to be enrolled in the Plan, such benefit credits will be carried forward into the following Plan Year and may be used to pay for covered expenses incurred in a subsequent period of coverage. The reimbursements will be charged against the remaining benefit credits. In addition, any Flat HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the run-out period of the Plan Year in which the medical care expense was incurred, shall be forfeited.

Revocation and Modification of Elections

- A. Once an eligible employee has elected benefits under the plan and the plan year has begun, he may not amend or revoke his election of benefits, unless there is a change in status or as may otherwise be permitted under this Section 3. The revocation of a designation of Benefits and election of new benefits may be made by an eligible employee only if both the revocation of existing designation of benefits and election of new benefits are made on account of and consistent with the previously described change in status (except for coverage under COBRA as defined in Section 5.)
- B. Change in coverage.

A participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the employer of the participant's spouse, former spouse, or dependent's employer, if (a) the accident and health plan in which the spouse, former spouse, or dependent participates permits its participants to make an election change that would be permitted under Treasury regulation Section 1.125-4(b) through (g); or (b) the participant's plan year period of coverage is different from the plan year period of coverage under the cafeteria plan or benefit plan of the plan in which the spouse, former spouse or dependent participates.

Where there is a judgment, decree, or order (including a qualified medical child support order (QMCSO) ("Order") resulting from a participant's divorce, annulment, legal separation, or change in custody, (a) a participant's election under this Plan may be changed to provide coverage for a dependent who is the participant's child if the order requires such coverage, and (b) coverage of the

dependent who is the participant's child may be revoked or changed if the Order requires someone other than the participant to provide such coverage.

If a participant, his spouse or dependent is entitled to special enrollment rights under a group health plan, as required by Code Sec. 9801(f) (i.e., HIPAA), then a participant may revoke a prior election for coverage under this Plan and make a new election, provided that the election corresponds with such special enrollment rights under the group health plan.

A participant entitled to make a new election under this Section 3 must do so within 30 days of the event or within 60 days of the change of status events (f) & (g) outlined in Section 1 above. Any such election shall apply for the balance of the Plan Year in which the election is made unless a subsequent event (described in this Section 3) occurs.

Reimbursements

Except as otherwise provided in this plan, contract or arrangement established to provide benefits of this Plan, reimbursement of expenses shall be made at such time and in such amounts as are evidenced by submitted proof of incurring an eligible medical expense by the Employer or by any administrator appointed by the Employer, provided sufficient benefit credits are available in the account of the participant. No payment may be made for any medical expense incurred by the participant before the participant's effective date of coverage or incurred on or after the date of actual termination of participation. However, a terminated participant (or the participant's estate) may claim reimbursement for any eligible medical expenses incurred during the period from the beginning of the calendar year through the date of termination of participation, provided that the participant (or the participant's estate) files a claim within 90 days of the termination. Any reimbursements from the Flat HRA Account for eligible medical expenses incurred after the date of termination will be made pursuant to an account being vested allowing for spend down or a COBRA election. Provisions for reimbursement of expenses by the Employer will be determined by the Employer who is the sole source of payment of benefits.

If a Participant in the Plan described by this Plan Document also participates, during the current Plan Year, in a Flexible Medical Spending Account (FSA) via a Flexible Benefit Plan, sanctioned by Section 125 of the Internal Revenue Code, and the funds available for claim payment elected in the FSA are exhausted, expenses claimed against the FSA may instead be claimed against the Fixed Contribution Health Reimbursement Arrangement (Flat HRA) described in this document, if it has available funds.

Nondiscrimination

Benefits under the Plan shall not discriminate in favor of highly compensated employees nor shall the aggregate cost of the benefits provided to key employees exceed 25% of the aggregate of such cost for the benefits provided to all employees under the Plan. The Employer may limit or deny any employee's participation in the Plan to the extent necessary to avoid any such discrimination due to actuarial error in rate calculation. This calculation shall be the property of and retained by the appropriate participating Employer.

Termination of Employment

An employee who retires during a Plan Year in which he participates in this Plan may continue to be an active participant in the Plan provided they have completed 10 years of employment with the City of Marquette. Eligible retired employees will be allowed to continue to submit expenses to exhaust their remaining balance but will receive no additional benefit credits to their Flat HRA account after retirement. The retiree will be responsible for paying the monthly administration fee associated with their Flat HRA.

Employer elects to allow continuation of any participant upon termination of employment. COBRA Continuation is available for such participant.

An employee who terminates during a Plan Year in which he participates in this Plan may continue to be an active participant in the Plan provided they have completed 10 years of employment with the City of Marquette. Eligible terminated employees will be allowed to submit expenses to exhaust their remaining balance but will receive not additional benefit credits to their Flat HRA account after termination. The terminated employee will be responsible for paying the monthly administration fee associated with their Flat HRA.

Employer elects not to allow continuation of any participant upon termination of employment that has not completed 10 years of employment. COBRA Continuation is available for such participant.

Forfeiture

Unless an account is vested allowing for spend down or COBRA is elected, if the total benefit credits paid or reimbursed to a participant with respect to any Plan Year are less than the benefit credits allocated, the unused portion shall be forfeited 90 days following an employee's date of termination of employment.

Participation Following Termination of Employment or Loss of Eligibility

If a participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days of the date of the termination of employment, the resulting break in employment will be disregarded for purposes of determining whether the employee is an eligible employee, and the rehired employee will be reinstated with a Flat HRA contribution amount based on enrollment level, provided the individual is enrolled in the HDHC Plan and meets the other requirements to be an eligible employee (disregarding the break in employment). Participants with 10 or more years of service prior to termination rehired within 30 days that do not meet the requirements to receive additional contributions may continue to receive reimbursements from the Plan until their unused account balance has been exhausted.

If an employee (whether or not a participant) terminates employment and is not rehired within 30 days or ceases to be an eligible employee for any other reason for more than 30 days (including, but not limited to, a reduction in hours or loss of HDHC Plan coverage), the employee's service before his or her loss of eligible employee status will not be taken into account when determining whether the employee has regained eligible employee status, so the employee will be required to complete the

waiting period before again becoming eligible to receive contributions in the Plan, provided the individual is enrolled in the HDHC Plan and meets the other requirements to be an eligible employee. During the waiting period, eligible Participants with spend down accounts may continue to receive reimbursements from the Plan until their unused account balance has been exhausted. Eligible Participants rehired beyond 30 days from termination that do not meet the requirements to receive additional contributions may continue to receive reimbursements from the Plan until their unused account balance has been exhausted provided their account was vested at termination.

Participation While on FMLA Leave

A participant who takes a paid or unpaid leave of absence under the Family and Medical Leave Act of 1993 (“FMLA Leave”) may continue participation in this Plan. A participant who elects to continue participation under this Plan shall be responsible for paying the premium on a schedule agreed to by the employer during the period of the FMLA leave. The Employer will provide such benefit credits that would normally be provided to such participant during the FMLA leave. The Plan Administrator shall determine the manner in which such benefit credits are applied to the participant’s account in its sole discretion.

Uniformed Service under USERRA

A participant who is absent from employment with the Employer on account of being in “uniformed service”, as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), will continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the participant fails to apply for reinstatement or to return to employment with the Employer. Benefit credits remaining at the time active employment ceases may be used as provided in the Plan except that no qualified medical expense will be considered for reimbursement when the cost of the medical service was available for payment or coverage by any other accident and health plan to which the participant is entitled. All unused benefit credits remaining in the Flat HRA account will be held in the account until such time as the employee returns to active employment, and then be available for reimbursement for qualified medical expense. If such participant returns to active employment before the expiration of the 24-month period indicated above, the participant will be reinstated, provided the former participant also is reinstated in the Employer’s accident and health plan concurrently, and in the same manner as existed before the USERRA commenced. The Employer will provide such benefit credits that would normally be provided to such participant during the remainder of the current Plan Year. The Employer or Plan Administrator shall determine the manner in which such benefit credits are applied to the participant’s account in its sole discretion.

Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a paid or unpaid leave of absence that does not affect eligibility, the Employer will continue to maintain the Participant’s Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee for a period of up to one year. If a Participant goes on a paid or unpaid leave of

absence that does affect eligibility, the Participant will be treated as having terminated participation, and COBRA will be offered.

Claims Appeals

Participants have a right to appeal claim payment determinations. If Participants disagree with any claim payment determination, then said Participant must submit proof that a claim for benefits is covered and payable under the Plan's provisions; including (a) all facts and theories supporting the claim, and (b) a statement within the referenced Plan provision. If the participant does so, it may be that some or the entire claim will be payable under the Plan. This Plan allows for two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination. Participant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by contacting the Plan Administrator. Briefly, the claimant may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: 44North, 1406 N. Mitchell Street, Cadillac, MI 49601, Attn: Claims Appeals. If participant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 60 days after receipt of the appeal. Participants are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to a claim for benefits. If Participants receive an adverse benefit determination following the final appeal, Participants have the right to bring a civil action. An external review process shall be provided as legally required.

Section IV

Administration

Enrollment

An eligible employee may request Participation in the Plan by completing the Enrollment Form supplied by the Employer or Plan Administrator. No eligible employee may enroll in this Plan unless and until he concurrently enrolls at the same time, in the Employer's accident and health plan.

Administrator

The Employer shall be the Plan Administrator.

Plan Year

The Plan Year will begin Friday, July 01, 2022 and ends Friday, June 30, 2023. The subsequent Plan Year will begin Saturday, July 01, 2023 and every July 1 thereafter.

Name of Plan and Employer Plan Identification Numbers

The name of this Plan is the City of Marquette Fixed Contribution Health Reimbursement Arrangement Plan.

The Employer Identification Number (EIN) assigned to the City of Marquette by the Internal Revenue Service (IRS) is 38-6004521. The Plan Number (PN) assigned to the Plan by the Employer is 502.

Service of Legal Process

The Employer has designated the Plan Administrator as its agent for service of legal process in connection with claims under the Plan. Such process may be served on the Employer by directing the process to the Plan Administrator indicated above.

Classification and Funding

The Plan is intended to be a Fixed Contribution Health Reimbursement Arrangement as defined under IRS Notice 2002-45. The medical care expenses reimbursed under the Plan are intended to be eligible for exclusion from participant's gross income under Code §105(b). This Plan is intended to be an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder, and to satisfy the minimum value method of integration described in IRS Notice 2013-54 and DOL Tech. Rel. 2013-3, through integration with the HDHC Plan. This Plan and the HDHC Plan shall be interpreted to accomplish these objectives.

The Employer funds the full amount of the Flat HRA accounts. There are no participant contributions for benefits under the Plan, except as provided in the case of COBRA coverage. Under no circumstances will the benefits be funded with salary reduction contributions, employee contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as employee contributions to the Plan.

The benefits provided under the Fixed Contribution Health Reimbursement Arrangement Plan are not insured. In the event the Plan or Plan Sponsor does not pay medical expenses that are eligible for payment under the plan for any reason, the participant may be responsible for the expenses.

Third-Party Administrator

The Plan may from time to time employ the services of a Third-Party Administrator (TPA) for designated Plan administration, or other qualified professionals for Plan services, under the direction of the Plan Administrator.

The Plan has contracted with a TPA to administer benefits and process claims. The TPA merely processes claims and does not ensure that any medical expenses of individuals covered by the Plan will be paid. Complete and proper claims for benefits made by participants covered by the Plan will be promptly processed; however, in the event there are delays in processing claims, plan participants have no greater rights to interest or other remedies against the TPA except those permitted by law.

Named Fiduciary

The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration, which has been delegated by the Employer, and any references to the Employer shall instead apply to the delegate. However, if the Employer assigns any of the Employer's responsibility to an employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

Rules of Administration

The Plan Administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them. The Plan Administrator has the discretionary authority to construe and interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Plan Administrator shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and such action shall be conclusive. The Plan Administrator shall prescribe procedures to be followed and the forms to be used by employees and participants to enroll and submit claims pursuant to this Plan and has the authority to request and receive from all employees and participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan. Records of administration of the Plan shall be kept, and participants and their beneficiaries may examine records pertaining directly to themselves.

Services to the Plan

The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical and other services to carry out the provisions of the Plan. The costs of such services and other administrative expenses shall be paid by the Employer.

Funding Policy

Each participant's benefits under the Plan shall be paid from Employer's general assets. Nothing in the Plan shall be construed to require Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no other trust or other fund from which benefits are paid. The Employer will make available 1/12th of the annual benefit times the number of remaining months in the Plan Year for single and family coverage elections by employees.

Claims Procedure

- A. To receive benefits under the Plan, a participant must submit a written claim for benefits to the Plan Administrator no later than 90 days following the close of the Plan Year in which the medical care expense was incurred (except that for a participant who ceases to be eligible to participate, this must be done no later than 90 days after that eligibility ceases). Third Party documentation submitted with the claim must set forth:

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- The individual(s) on whose behalf medical care expenses have been incurred;
 - The date the medical care expenses were incurred;
 - The type of medical care;
 - The name of the provider of the medical care;
 - The amount of the service and reimburse amount;
 - Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition)
- B. For purposes of the claims procedure, the Employer will assign a person or a committee, to be the Claims Administrator. The Claims Administrator will review the claim and will advise the participant of any benefit to which he is entitled.

If a participant believes he has not been reimbursed in accordance with the Plan or has not been advised of his benefits, he may submit a written request to the Plan Administrator to provide either an explanation of how benefits are reimbursed or further information of his benefits. The Plan Administrator must respond to such a request within a reasonable time. Additionally, the Plan Administrator will provide to every claimant, who is denied a claim for benefits, a written notice stating in a format determined to be understood by the claimant:

- (i) the specific reason or reasons for the denial;
- (ii) specific reference to pertinent Plan provisions on which the denial is based;
- (iii) a description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary; and
- (iv) an explanation of the claim review procedure set forth in Paragraph C., below.

Such notice will be given within 30 days after the claim is received by the Claim Administrator (or within 45 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 30-day period). If such notification is not given within such period, the claims will be considered denied as of the last day of such period, and such person may then request a review of his claim, as set forth in subsection C., below.

- C. Within 180 days of receipt by a claimant of a notice denying a claim under Paragraph A., the claimant or his duly authorized representative may request in writing a full and fair review of the claim by the Plan Administrator, or by the Committee which may be appointed by the Employer for that purpose. The Claim Administrator or committee may extend the 180-day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, the claimant or his duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Claim Administrator or committee shall make a decision promptly, and not later than 60 days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

Overpayments or Errors

If it is later determined that the participant and/or the participant's spouse or dependent(s) received an overpayment or a payment was made in error, whether it is due to a mistake as to the eligibility of participation or the allocations made to your Flat HRA or an adjustment made by the HDHC, you will be required to refund the overpayment or erroneous reimbursement to the Flat HRA Plan.

If the overpayment or erroneous payment is not refunded, the Flat HRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your compensation.

Nondiscriminatory Operation

All rules, decisions and designations by the Employer, Claim Administrator, and each committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

Liability of Administrative Personnel

Neither the Employer nor any of its employees shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

Participant's Health Information

THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT PLAN PARTICIPANTS MAY BE USED AND DISCLOSED AND HOW PLAN PARTICIPANTS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a Health Plan subject to HIPAA, the plan shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

The Protected Health Information (PHI) provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations (“Rules”) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (“HITECH”) include privacy protections impacting handling of the group health plan medical or financial information that could identify an individual.

Protected Health Information (PHI) is information created or received by plans subject to HIPAA that relates to the past, present or, future individual’s physical or mental health condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Protected Health Information (PHI) provisions of HIPAA and its rules include privacy protections impacting group handling health plan medical or financial information that could identify an individual. Individually identifiable information is protected whether it is in electronic, paper or oral format. The HIPAA rules give individuals control over health and financial information related to their health care. PHI may be used only for limited purposes without consent, and in many situations, only upon individual authorization. Regarding their own PHI, they have the right to:

- A. Object to using information;
- B. Gain access to information;
- C. Change information; and
- D. Obtain an accounting of any information disclosures.

An underlying principle of the rules is that the “minimum necessary” disclosure should be the standard when using or disclosing information in the normal course of treatment, payment or health plan operations.

Participants in this plan are guaranteed access to their PHI and have the right to: (1) copy and amend health information; (2) receive an accounting of PHI uses; and (3) receive notices of health plans’ privacy practices. Individuals have the right to request that PHI use and disclosure be restricted even for treatment and payment purpose.

Certification Requirement

The Flat HRA shall disclose PHI, including Electronic PHI, to Authorized employees of the Employer only upon receipt of a certification by the Employer that the Employer agrees:

- A. not to use or further disclose PHI other than as permitted or required by the Privacy Policy or as required by law;
- B. to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;
- C. not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;
- D. to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures, or any security incident, of which the Employer becomes aware;
- E. to make available PHI for inspection and copying in accordance with 45 CFR §164.524;
- F. to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;
- G. to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- H. to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;
- I. if feasible, to return or destroy all PHI and Electronic PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible and Electronic PHI;
- J. to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

- K. to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

Electronic Data Security Obligations

To the extent the Plan maintains electronic PHI, the Plan will:

- A. Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan as required by the HIPAA Security Rules;
- B. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan;
- C. Ensure that the separation is supported by reasonable and appropriate security measures;
- D. Ensure that any agents, including subcontractors, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect the electronic PHI; and
- E. Report to the Plan any security incident involving PHI including any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations of which it becomes aware.

Permitted Uses and Disclosures

The Plan places restrictions on the Employer's use or disclosure of PHI received from the plan or an insurer. Insurers may determine what information will be available to the Plan.

Only Authorized employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Authorized employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan.

The HIPAA Plan may disclose PHI to the Authorized employees of the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Authorized employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the plan and agree to use and disclose PHI only as permitted or required by HIPAA. This includes:

- A. Plan's own Payment and Health Care Operations functions including;
 - 1. Enrollment of eligible individuals;
 - 2. Eligibility determinations;

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3. Payment for coverage;
 4. Claim payment activities;
 5. Coordination of benefits; and
 6. Claims appeals.
- B. Another HIPAA Health Plan's Payment and Health Care Operations functions;
- C. Disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;
- D. Disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;
- E. Disclosures of a participant's, spouse's, or dependent's PHI to the participant or the dependent or his or her personal representative, as defined under 45 CFR §164.502(g);
- F. Disclosures to a participant's, spouse's, or dependent's family members or friends involved in the participant's, spouse's, or dependent's health care or payment for the participant's, spouse's, or dependent's health care, or to notify a participant's, spouse's, or dependent's family in the event of an emergency or disaster relief situation;
- G. Uses and disclosures to comply with workers' compensation laws;
- H. Uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;
- I. Disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;
- J. Uses and disclosures for other governmental purposes, such as for national security purposes;
- K. Uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- L. Uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;
- M. Uses and disclosures required by other applicable laws;

- N. Uses and disclosures pursuant to the participant's authorization that satisfies the requirements of 45 CFR §164.508;
- O. Enrollment of eligible individuals;
- P. Eligibility determinations; and
- Q. Payment for coverage;

The Plan will meet the minimum necessary uses and disclosures provisions of HIPAA for PHI. However, the minimum necessary provisions *do not apply* to the following:

- A. Disclosures to or request by a health care provider for treatment purposes;
- B. Disclosures to the individual who is the subject of the information;
- C. Uses or disclosures made based on an authorization requested by the individual;
- D. Uses or disclosures required for compliance with HIPAA's transaction standards (see 813);
- E. Disclosures to HHS when the rule requires the disclosure of information for enforcement purpose; or
- F. Uses or disclosures that are required by other laws.

Any uses or disclosures for which the covered entity has a valid authorization are exempt.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Marketing

The group health plan(s) and other covered entities, as defined by HIPAA, will not use or disclose PHI for marketing purposes without the individual's authorization, except for face-to-face communications with the individual or promotional gifts of nominal value.

Communications that are part of treatment or are about a plan's benefits, services or operations are excluded from the definition of marketing, even if they promote the use or sale of a service or product. Specifically excluded from the definition of marketing communications about:

- A. Participating providers and health plans in a network, the services offered by a provider or the benefits covered by a health plan;
- B. Treatment of the individual; and

- C. Case management or care coordination for the individual, or directions or recommendations for alternative treatments, therapies, health care providers or settings of care to that individual.

This health plan is not engaging in marketing when it advises enrollees about other available health coverage that could enhance or substitute for existing health coverage. For example, if a child is about to age out of coverage under a family policy, the plan may send the family information about continuation coverage for the child. This exception does not extend to excepted benefits under HIPAA, such as accident-only policies or auto medical liability, nor to other lines of insurance.

It is not marketing for this plan to communicate about health-related products and services available only to plan enrollees or members that add value to but are not part of a plan of benefits. To qualify for this exclusion, the communication must meet two conditions:

- A. It must be health-related. For example, offers of discounts for eyeglasses may be considered part of plan benefits. This exclusion appears to include wellness programs that offer incentives to adopt healthy lifestyle behaviors.
- B. It must offer an added value of plan membership and not merely be a pass-through of a discount or item available to the public at large.

For marketing activities permitted by an authorization, if there is remuneration, the marketing material must state that the entity making the communication is being paid by another entity.

Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health information is prohibited in the following situations:

- A. *Genetic Information.* Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
- B. *Employment-Related Actions.* Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.
- C. *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted above, shall not be a permitted use or disclosure.

Plan administration functions do not include functions performed by the Employer for employment-related functions.

The Authorized employees will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of the Plan.

Underwriting

An insurer that receives protected group health plan information for underwriting, premium rating and other similar purpose – and that coverage is not placed with the insurer- cannot use or disclose the information for any purpose other than as required by law.

Verification

In any disclosure, other than those allowing the individual to agree or object, verification of the identity of anyone requesting PHI who is not known to the health plan or other covered entity must first occur.

If disclosure is conditional on documentation or statements from the person seeking PHI, that documentation or statement must be obtained before the PHI can be disclosed.

Breach Notification

Following the discovery of a breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Section V

Continuation of Coverage

In General

The following provisions shall apply to benefits provided to eligible employees and their dependents under the plan, but only to the extent that the benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA) unless the employer is exempt.

Continuation of Coverage

To the extent required by COBRA, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation

coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a covered employee or spouse of the covered employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

Employer elects to allow continuation of any participant upon termination of employment that has completed 10 years of service. COBRA does not have to be elected to spend down the balance on vested accounts. No additional benefits will be credited without a COBRA Continuation election.

Employer elects not to allow continuation of any participant upon termination of employment that has not completed 10 years of employment. COBRA Continuation is available for such participant.

If an employee (whether or not a participant) terminates employment and is not rehired within 30 days for any other reason, including, but not limited to, a reduction in hours, and then becomes an eligible employee again, the employee will be treated as new and must re-satisfy (complete the waiting period) Plan eligibility requirements before receiving contributions to the plan. During the waiting period, the participant may continue to receive reimbursements from the plan until their unused account balance has been exhausted.

If terminated employee is rehired within 30 days or less after the date of termination of employment and is otherwise eligible to participate in the Plan, then the employee may immediately rejoin the Plan and be reinstated with the same Flat HRA account contributions amounts based on enrollment level that such individual had before termination.

If an employee (whether or not a participant) ceases to be an eligible employee for any reason (other than for termination of employment), including, but not limited to, a reduction of hours, and then becomes an eligible employee again, the employee may rejoin the Plan without having to re-satisfy (complete the waiting period) Plan eligibility requirements.

Type of Coverage

Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

You may have other options available when you lose group health coverage

For example, you may be eligible to buy an individual plan through the health insurance marketplace. By enrolling in coverage through the marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Coverage Period

The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

- A. in the case of a terminated employee (except for gross misconduct) or a covered employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;
- B. in the case of a qualified beneficiary disabled during the first 60 days following the covered employee's termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event;

Note: The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The qualified beneficiary receiving the disability extension is required to notify the Plan Administrator if the SSA makes such a determination, and you must provide this notice within the 30-day period after the SSA makes such a determination. Such a notice is to be in writing and delivered in person or mailed to the Plan Administrator.

- C. in the case of a terminated employee (except for gross misconduct) or covered employee whose hours have been reduced, and the employee became entitled to Medicare less than 18 months before the qualifying event, for the covered dependents, the date which is 36 months after the date of Medicare entitlement.
- D. in the case of a second qualifying event, which includes the death of a covered employee, the divorce of a covered employee and spouse, or a loss of dependent status under the plan, which occurs during the 18-months after the date that a covered employee is terminated (except for gross misconduct) or the date that a covered employee's hours are reduced, you may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage). The affected individual is entitled to this continuation coverage period only if it would have caused loss of coverage under the plan, in the absence of the first qualifying event. The affected individual is required to notify the Plan Administrator in the same manner as Section B Above.

- E. in the case of any qualifying event except as described in A., B., and C. above, the date which is 36 months after the date of the qualifying event;
- F. the date on which the Employer or a Participating Employer, if any, ceases to provide any group health plan to any employee;
- G. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;
- H. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect (taking into account, for plan years commencing after June 30, 1997, prior creditable coverage under the portability rules of the Health Insurance Portability and Accountability Act of 1996). In no event will coverage continue longer than the coverage period as set forth in this Section.
- I. the right of continuation coverage under the Plan may be terminated prior to the end of the continuing coverage period if the individual engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary.
- J. the Plan Administrator is required to give notice of Unavailability of Continuation Coverage should the rights of continuation coverage be denied or terminated. This Notice of Unavailability of Continuation Coverage will state the specific reason for denial of the claim for continuation coverage. The individual will be notified of the date the coverage will terminate, and the reason for termination and the rights the qualified beneficiary may have under the plan or applicable law, or to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Contribution

- A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer or a participating Employer in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments. The election notice will contain complete information as to the amount of the premium required.
- B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.
- C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium

for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

- D. Certain individuals may be eligible for a Federal Income tax credit as a result of the Trade Adjustment Assistance Reform Act of 2002 (HCTC). This tax credit helps pay for the premium of continuation coverage. An individual who loses a job due to the effect of international trade may be entitled to this tax credit (payable in some cases directly to the employer to offset the cost of the premium) and qualify for trade adjustment assistance. Those receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) may become entitled to the tax credit as well. If you become entitled to this tax credit, contact HCTC Customer Contact Center at 1-866-628-4282.

Notification by Qualified Beneficiary

Each covered employee or qualified beneficiary must notify the Employer or a participating Employer of the occurrence of a divorce or legal separation of the covered employee from such covered employee's spouse, and/or the covered employee's dependent child ceasing to be a dependent child under the terms of this Plan within **60** days after the date of such occurrence.

Keep Your Plan Informed of Address Changes. In order to protect you and your family's rights, you must keep the Plan Administrator informed of any changes in the addresses of yourself and/or family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notification Procedure

Any notice that you provide must be in writing addressed to the Plan Administrator. Oral notice, including notice by telephone, is not acceptable. Electronic notices (email or fax) are not acceptable. Your notice must be complete and must be postmarked no later than the last day of the required notice period. Your notice must state the name and address of the Employer, the name of the group health plan, the name and address of the employee covered under the plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened. Your notice of a second qualifying event must also name the event and the date it happened.

Your notice of a child's loss of dependent status must include documentation of the date of the qualifying event (i.e., a birth certificate). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If the qualifying event or the second qualifying is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability or cessation of disability must include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled or ceased to be disabled and the date the Social Security Administration made its determination. Your notice of disability or cessation of disability must include a copy of the Social Security Administration's determination.

Notification to Qualified Beneficiary

- A. The Employer shall provide written notice to each covered employee and spouse of such covered employee of his/her right to continuation coverage under this provision as required by federal law.
- B. The Employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered employee from the covered employee's spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, City of Marquette, shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered employee or the qualified beneficiary notifies City of Marquette of such qualifying event.
- C. Notification of the requirements of this provision to the spouse of a covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made.

Section VI

Definitions

- A. **“Dependent”** means (a) any individual who is a participant's child as defined by Code §152(f)(1) and who has not attained age 27, and (b) any tax dependent of a participant as defined in Code §105(b) provided, however, that any child to whom Code §152(e) (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies is treated as a dependent of both parents. Notwithstanding the foregoing, the Flat HRA Account will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of “dependent.”
- B. **“Election Period”** means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60 day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.
- C. **“Full-Time Student”** means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain full-time student status.
- D. **“Medicare”** means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

E. **“Qualified Beneficiary”** means an individual who, on the day before the qualifying event for a covered employee, is a beneficiary under this Plan as the dependent (as defined in Section 1 hereof) of the covered employee. In the case of the termination of a covered employee (except by reason of such covered employee’s gross misconduct) or the reduction in hours of the covered employee’s employment, the term qualified beneficiary includes the covered employee. Effective January 1, 1997, a child who is born to (or placed for adoption with) a qualified beneficiary who is a covered employee during the coverage period shall also be a qualified beneficiary.

Exception - the term qualified beneficiary does not include an individual whose status as a covered employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the Employer which constituted income from sources within the United States (within the meaning of Code section 911(d)(2) and section 861(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

F. **“Qualifying Event”** means with respect to a covered employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

(i) the death of the covered employee;

(ii) the termination (except by reason of such covered employee’s gross misconduct) or reduction in hours of the covered employee’s employment;

(iii) divorce or legal separation of the covered employee from such covered employee’s spouse, as herein defined;

(iv) the covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);

(v) a dependent child who ceases to be a dependent child under the terms of this Plan;

(vi) the Company’s filing for Chapter 11 reorganization as it would affect retiree coverage.

G. **“University/College”** means an accredited institution listed in the current publication of accredited institutions of higher education.

Section VII

Miscellaneous

Amendment and Termination

This Employer or its authorized representative may amend or terminate this Plan at any time by action of the Commission. The Employer may amend this Plan retroactively to enable the Plan to qualify as a cafeteria Plan under sections 105 and 106 of the Code. No amendment shall deprive any participant or beneficiary of any

benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

Effect of Plan on Employment

The Plan shall not be deemed to constitute a contract of employment between the participating Employer and any participant or to be a consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the participating Employer or to interfere with the right of the Employer to discharge any participant or employee at any time regardless of the effect which such discharge will have upon him or her as a participant of this Plan.

Alienation of Benefits

The right of any participant to receive any reimbursement under this Plan shall not be alienable by the participant by assignment or any other method and shall not be subject to claims by the participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Facility of Payment

If the Employer deems any person incapable of receiving benefit to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Employer to disburse it, whose receipt shall be a complete release of the Employer and shall be deemed full payment of the benefit. Such payments shall, to the extent thereof, discharge all liability of the Employer.

Proof of Claim

As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Employer may require either directly to the Employer or to any person delegated by it.

Status of Benefits

The Employer believes that this Plan is in compliance with section 105 of the Code and that it provides certain benefits to employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval, and thus there can be and is no guarantee that intended tax benefits will be available. Any participant, by accepting benefits under this Plan, agrees to be liable for any tax plus interest that may be imposed with respect to those benefits and is obligated to notify the administrator if the participant has any reason to believe that such payment is not excludable from the participant's gross income for federal, state, or local income tax purposes.

If any participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such participant shall indemnify and reimburse the Employer for any liability it

may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Applicable Law

The Plan shall be construed and enforced according to the laws of the State of Michigan to the extent not pre-empted by any federal law.

Lost Distributees

Any benefit payable hereunder shall be deemed forfeited if the Employer is unable to locate the participant to whom payment is due, provided, however that such benefit shall be reinstated if a claim is made by the participant for the forfeited benefit.

Source of Payments

The Employer and any insurance company contracts purchased or held by the Employer shall be the sole sources of benefits under the Plan. No employee or beneficiary shall have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such employee or beneficiary.

Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

Severability

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Heirs and Assigns

This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each participant and beneficiary.

Headings and Captions

The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

Tax Effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether or not payments received by a participant under the Plan will be treated as includible in gross income for federal or state income tax purposes.

Multiple Functions

Any person or a group of persons may serve in more than one fiduciary capacity with respect to the Plan.

Gender and Form

Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

Prior Year Claims Run Out Period

Claims can be submitted up to 90 days past the end of the Plan Year. Claims received after 90 days are subject to Carrier and Administrator approval.

No Reversion to Employer

At no time, shall any part of Plan assets be used for, or diverted to, purposes other than for the exclusive benefit of Plan participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

Executed this Date: 01-31-2023

ATTEST: City of Marquette

BY: _____ **(Authorized Officer)**

_____ **(Printed)**

_____ **(Title)**

**City of Marquette
Fixed Contribution Health Reimbursement Arrangement (Flat HRA)
Plan Document
Amended February 01, 2023**

Schedule A

Schedule of Benefits

PLAN YEAR: July 1, 2018 through June 30, 2019

For Participants enrolled as Single Participants:	\$28.30 Bi-Weekly	\$ 735.80 Annual*
For Participants enrolled as 2-Person Coverage:	\$74.36 Bi-Weekly	\$1,933.36 Annual*
For Participants enrolled with Family Coverage:	\$94.10 Bi-Weekly	\$2,446.60 Annual*

PLAN YEAR: July 1, 2019 through June 30, 2020

For Participants enrolled as Single Participants:	\$28.39 Bi-Weekly	\$ 738.14 Annual*
For Participants enrolled as 2-Person Coverage:	\$74.57 Bi-Weekly	\$1,938.82 Annual*
For Participants enrolled with Family Coverage:	\$94.36 Bi-Weekly	\$2,453.36 Annual*

PLAN YEAR: July 1, 2020 through June 30, 2021

For Participants enrolled as Single Participants:	\$25.15 Bi-Weekly	\$ 653.90 Annual*
For Participants enrolled as 2-Person Coverage:	\$65.88 Bi-Weekly	\$1,712.88 Annual*
For Participants enrolled with Family Coverage:	\$83.34 Bi-Weekly	\$2,166.84 Annual*

PLAN YEAR: July 1, 2021 through June 30, 2022

For Participants enrolled as Single Participants:	\$27.73 Bi-Weekly	\$ 720.98 Annual*
For Participants enrolled as 2-Person Coverage:	\$72.23 Bi-Weekly	\$1,877.98 Annual*
For Participants enrolled with Family Coverage:	\$91.29 Bi-Weekly	\$2,373.54 Annual*

PLAN YEAR: July 1, 2022 through June 30, 2023

For Participants enrolled as Single Participants:	\$26.94 Bi-Weekly	\$ 700.44 Annual*
For Participants enrolled as 2-Person Coverage:	\$70.21 Bi-Weekly	\$1,825.46 Annual*
For Participants enrolled with Family Coverage:	\$88.75 Bi-Weekly	\$2,307.50 Annual*

*** Maximum benefits that may be credited to a Flat HRA account for an Employee who participates for an entire 12-month period of coverage. Yearly maximum benefit subject to change based on the periodically adjusted cap limits set by Department of Treasury for the State of Michigan.**

Employer contributions to the Plan will be made pro rata on a bi-weekly basis.

If the Employee enrolls in this Plan coincidentally with the Employers group accident and health Plan other than on a Plan anniversary, the Employer's annual contribution to the Participant's Fixed Contribution Health Reimbursement Arrangement account will be an amount equal to 1/12th of the amounts shown above multiplied by the number of whole months remaining until the end of the Plan Year.

Spend Down: While participating in the Plan, active Employees and Retirees or Terminated employees with vested accounts may continue to receive reimbursements from the Plan until their unused account balance has been exhausted. Upon retirement or leaving the City's HDHC with Buy-Down Plan, contributions will cease. Monthly administrative fees are deducted from remaining funds. All Flat HRA Plan rules apply until such credits are exhausted.

Vested: Unused benefit credits in an Active Employee not enrolled in the City's HDHC plan with Buy-Down option, a Retiree or a terminated Participant's Flat HRA account qualify for spend down. Retiree or terminated Participants must have completed at least 10 years of employment with the City of Marquette in order to be vested.

List of Participating Employers, if any, participating in the plan:

There are no other Employers affiliated with this plan.

Claims can be submitted to the Third-Party Administrator:

TPA Claims Administration by:

**44North – Cadillac Office
1406 N. Mitchell Street
PO Box 700
Cadillac, MI 49601**

Or Faxed to: (855) 306-1098

Submit Manual Claims to:

**44North – Marquette Office
620 S. Lake Street
PO Box 747
Marquette, MI 49855**

Or Faxed to: (855) 579-5044