

**City of Burlingame Post-Employment  
Health Reimbursement Arrangement**

**SUMMARY PLAN DESCRIPTION**

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Original Effective Date: November 1, 2016  
Plan Year: July 1 – June 30

**Employer Benefit Administrators**



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## **ARTICLE I. INTRODUCTION**

Your Employer, City of Burlingame (the "Employer"), is pleased to sponsor an employee benefit program known as the City of Burlingame Post-Employment Health Reimbursement Arrangement (the "Plan") for certain eligible employees.

This summary plan description ("SPD") describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. To make maximum use of this Plan, be sure to proceed through this booklet carefully, so that you can make informed decisions that are right for you.

If, for any reason, there is an omission or misstatement in this SPD, or any difference between this SPD and the Plan document, the Plan document shall in all respects control and govern. Please note that neither the Plan nor the SPD constitute a contract of employment.

In all situations involving the interpretation and clarification of a policy, procedure or application, the decision of the Plan Administrator will be final and binding. However, notwithstanding the prior sentence, any claim for benefits that a Plan Administrator denies is subject to review under the Plan's claims and appeals procedures, which are summarized herein.

If you have any unanswered questions after reading this SPD, please contact:

Employer Benefit Administrators, LLC  
3125 Airport Parkway N.E.  
Cambridge, MN 55008  
Phone number: 888-507-6053

## **PRIVACY NOTIFICATION**

The Plan is a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules.

HIPAA requires that "covered entities" protect the confidentiality of your protected health information (PHI). "Electronic PHI" or "E-PHI" means PHI that is transmitted in electronic media.

PHI means health information that:

- Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse;
- Related to the past, present and future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Either identifies the individual or reasonably could be used to identify the individual

A complete description of your rights under HIPAA can be found in the Plan's **privacy notice**, distributed to you upon enrollment and available upon request from your Plan Administrator.

The Plan will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment and health plan operations, expressly authorized by you or as required by law. The Plan requires all of its service providers to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receiving an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. You may find more information about HIPAA at the following website: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/>

## **ARTICLE II. GENERAL INFORMATION ABOUT THE PLAN**

### **2.1 What is the purpose of the Plan?**

The purpose of the Plan is to provide certain Employees with an opportunity to receive reimbursement for certain Health Care Expenses as provided in this Plan. It is the intention of the Adopting Employer that the benefits payable under this Plan be eligible for exclusion from the gross income of Participants as provided by Code §§ 105(b) and 106. In addition, it is the intention of the Adopting Employer that the Plan qualify as a Health Reimbursement Arrangement ("HRA") under IRS Revenue Ruling 2002-41, IRS Notice 2002-45, IRS Notice 2013-54, IRS Notice 2015-87 and Final Regulations jointly issued on November 18, 2015 by the Department of the Treasury (Internal Revenue Service), the Department of Labor (Employee Benefits Security Administration) and the Department of Health and Human Services, (i.e., Final Rules for Grandfathered Plan, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act.)

### **2.2 When did the Plan take effect?**

The Plan became effective November 1, 2016. It operates on a Plan Year specified in the Administrative Information included at the end of this SPD.

### **2.3 Compliant Plan Models**

Effective for Plan Years beginning on or after January 1, 2017, in order to comply with related legislation and regulatory guidance the Affordable Care Act ("ACA"), (which generally prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits), an HRA must fit into one of these compliant designs specified in the Adoption Agreement effective for Plan Years beginning on or after January 1, 2017:

- (a) Integrated HRA as described in regulatory guidance issued by the Federal government, specifically:
  - (1) FAQs About the Affordable Care Act Implementation (Part XI), on January 24, 2013; and
  - (2) IRS Notice 2013-54, and IRS Notice 2015-87 issued by the Department of Treasury, and related guidance issued by the Federal government relating to the Application of Reform and other provisions of the Affordable Care Act to HRAs, Health FSAs and certain other employer healthcare arrangements; and
  - (3) Final Regulations jointly issued by the Department of the Treasury (Internal Revenue Service), the Department of Labor (Employee Benefits Security Administration), and the Department of Health and Human Services on November 18, 2015, (i.e., Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual

Limits, Rescission, Dependent Coverage Appeals, and Patient Protections Under the Affordable Care Act.)

- (b) A Retiree-Only HRA as described in the same guidance listed above that has fewer than two active employees participating in the Plan on the first day of the Plan Year.
- (c) A restricted HRA that is limited to the reimbursement of vision and/or dental premiums and/or out-of-pocket expenses.
- (d) A "frozen" HRA that does not meet one of the three design criteria above and which no longer receives any contributions into the HRA. Although the HRA has been frozen, the amounts that have been contributed to the HRA Plan on a participant's behalf during Plan Years beginning before January 1, 2014, will continue to be available to that participant after December 31, 2013, to reimburse the Participant's eligible expenses under the terms of the HRA.

2013-2014 Transition Rule for Pre-2014 Amounts. Whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

This employer plan fits into the category described above of:

Retiree-Only HRA

2.4 [Who can participate in the Plan?](#)

An eligible employee, the legal spouse and legal dependent of the employee and any other person appropriately covered under the Plan.

In order to participate in this Plan, a person must be:

A benefit eligible employee of employer; and

Meets the eligibility requirements as contained in current collective bargaining agreements, individual personnel contracts, memorandum of understanding and/or compensation and benefit plan for eligibility requirements; and

A member of the Teamsters Local 856; or

A member of Burlingame Police Officers Association; or

A member of The Association of Police Administrators; or

A member of Burlingame association of Middle Managers; or

A member of AFSCME 829 or AFSCME 2190; or

A member of a Non-Union Group of Department Head and Unrepresented Classifications.

[Note: The Plan is maintained pursuant to a collective bargaining agreements and individual personnel contracts and copies of the relevant portions of that agreement may be obtained by Plan participants upon written request to the Plan Administrator. These employees are called Eligible Employees. Those Eligible Employees who actually participate in the Plan are called "Participants."

**"Employee"** means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including but not limited to an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer, but who is paid by a temporary or other employment agency such as "Kelly," "Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder.

**Annual Option to Permanently Opt Out.** *[Integrated HRA or Retiree-Only HRA]* Each year you are eligible for coverage under this HRA (and upon termination of employment) you have the right to permanently opt-out of participation in this HRA. Being eligible for HRA benefits means you are considered to be covered by an employer-sponsored health plan under federal health care rules and prevents you from being eligible for federal subsidies if you purchase health insurance coverage on the public marketplace exchange. Keep in mind that other factors, such as your household income, will impact whether you are eligible for subsidies to offset the cost of health insurance coverage you may purchase on the public marketplace exchange. If you elect to opt out of coverage under this HRA, you will not be allowed to re-enroll (and receive benefits using money deposited to your account) for the duration of the time you are eligible for coverage under the HRA. For information about federal health insurance rules, the public marketplace exchange and federal subsidies see <https://www.healthcare.gov/> or call 1-800-318-2596. To exercise your opt-out rights under this HRA, please obtain the opt out form from the Plan Administrator. Please contact the Plan Administrator with questions.

## 2.5 [How long will I be able to participate in the Plan?](#)

There are two aspects of participation in the Plan – the receipt of employer contributions and access to your HC Account to receive reimbursement of eligible Health Care Expenses.

**Contributions.** Contributions on your behalf cease upon the earliest of the following: (1) the date of your death; (2) the date of termination of your employment with the Employer; (3) the date of your failure to meet the eligibility requirements described in Section 2.3 other than the requirement that you be an employee of the Employer; or (4) the date of termination of the Plan.

**Access.** Access to your HC Account for purposes of reimbursing eligible Health Care Expenses cease upon the earliest of the following: (1) the date of your death; (2) the date the balance of your HC Account reaches zero, if no further contributions will be made to said account; or (3) the date of termination of the Plan.

**Please note:** Termination of contributions or access to your HC Account does not prevent you or others covered through you from receiving continuation coverage required by applicable law. In addition, termination of access to your HC Account is subject to the spend down access described in Section 5.2.

## **2.6 How long will the Plan remain in effect?**

Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate the program in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

## **2.7 How does reimbursement under this Plan affect my tax deductions?**

You should realize that any medical expense for which you are reimbursed under this Plan cannot be claimed as a medical expense deduction on your income tax return. Beginning January 1, 2013 unless your health expenses exceed ten percent (10%) of your adjusted gross income; or exceed seven and one half percent (7.5%) of your adjusted gross income if you are age 65 or older, you are not permitted to use the deduction anyway.

Note: Beginning Jan. 1, 2017, all taxpayers may deduct only the amount of the total unreimbursed allowable medical care expenses for the year that exceeds 10% of your adjusted gross income.

# **ARTICLE III. HEALTH CARE ACCOUNT**

## **3.1 What is my Health Care Account?**

A Health Care Account ("HC Account") will be established in your name to keep a record of the benefits under this Plan to which you are entitled. Your Employer will contribute a specified amount into your HC Account on a per pay period basis. If this amount changes, the new amount of the contribution will be communicated to you prior to the beginning of the following Plan Year. If you become a Participant mid-year, you will receive a pro-rata contribution for that year based upon the number of months remaining in the year at the time you become a Participant.

Your HC Account is an individual trust account established within an IRC 115 Trust. Benefits are paid from the Trust account.

You may receive reimbursement for eligible Health Care Expenses up to the amount of the balance in your HC Account at the time a reimbursement request is processed. Any balance remaining in your HC Account at the end of the Plan Year will be carried over to future Plan Years for the sole purpose of reimbursing you for your eligible Health Care Expenses.

If participant passes away without a spouse or dependents, the Plan shall provide that the participant's estate/family members shall have 12 months after participant's passing to submit any final and remaining medical expenses incurred by the participant not previously reimbursed. After the 12-month time period any remaining funds shall be forfeited and placed in a forfeiture account. Any funds placed in a forfeited account may be used by the employer to pay Plan administrative fees or may be used to fund future contributions into the plan.

After separation from employment if an account remains inactive for five years, funds will be forfeited but only after reasonable attempts have been made to locate the participant of the account. Note: it is the intent of the employer to maintain this plan indefinitely; however, the employer has the right to terminate the plan. After all benefits and administrative fees are paid as outlined in the Plan Document forfeited funds may revert back to the employer.

### 3.2 What is an “eligible” Health Care Expense?

Only eligible Health Care Expenses may be reimbursed under this Plan. An eligible Health Care Expense is an expense for the payment of Health Insurance Premiums as allowed by law, Health Care Out-Of-Pocket Expenses, Deductible-Only Expenses, and Vision and Dental expenses. Furthermore, to be an eligible Health Care Expense, the expense:

- (a) must be “incurred” while you are a Participant; and
- (b) must be “incurred” for yourself, your Spouse or your Dependent(s).

An expense is “**incurred**” when the service that gives rise to the expense has been provided, not when you are billed or when you pay the expense.

“**Spouse**” means an individual who is legally married to you and who is treated as your spouse under the Internal Revenue Code.

“**Dependent**” means a dependent for purposes of Section 105 of the Internal Revenue Code. Generally, “dependent” includes a qualifying child that has not attained aged 27 in the tax year. The other relatives that may be “dependents” for purposes of the Plan are individuals who: (a) are your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent’s ancestor), stepparent, brother or sister’s son or daughter, parent’s brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household; (b) generally have received more than one-half of their support from you during the relevant year; and (c) are not a qualifying child of you or someone else.

### 3.3 How do I receive my benefits under the Plan?

When you incur an expense that is eligible for reimbursement, you must submit a claim to the Claims Administrator on an administrative form that will be supplied to you. The form will typically require:

- (1) the amount, date and nature of the expense,
- (2) the name of the person or entity to which the expense was paid,
- (3) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and
- (4) such other information as the Claims Administrator may require.

You shall also be required to submit copies of bills or receipts from the provider(s) to support your claim.

“**Claims Administrator**” means Employer Benefit Administrators, LLC. The address for claims submission is: 3125 Airport Parkway N.E., Cambridge, MN 55008. The phone number is 888-507-6053.

### 3.4 What if my claim exceeds the balance of my HRA Account?

The maximum reimbursement you may receive at any time is the amount of your HC Account balance at the time the reimbursement request is processed. The maximum reimbursement requirements apply to you, your Spouse, and your Dependent(s) on an aggregate basis, not an individual basis. If your claim is for an amount that is more than your current HC Account balance, the excess, unreimbursed part of the claim will be carried into the subsequent month(s), to be paid as the balance of your HC Account becomes adequate. However, an unreimbursed portion of a claim will not be carried

over into subsequent months if: (1) the claim has been pending at least eighteen (18) months, and (2) no further contributions will be made to your HC Account.

### **3.5 Do I submit claims for reimbursement under my Employer's cafeteria plan first?**

Yes. Claims for eligible Health Care Expenses (see Question 3.2) must first be submitted for reimbursement to your Employer's flexible spending account under its cafeteria plan. If that claim is not fully reimbursed, the balance may then be submitted under this Plan.

### **3.6 What happens if my claim for benefits is denied?**

In most cases, within thirty (30) days after a claim for benefits is filed, the claim will either be paid or the Claims Administrator will notify you of the claim denial. If the Claims Administrator denies the claim, you will be provided with the following information in writing:

1. The specific reasons for the denial;
2. The specific reference to the Plan provisions on which the denial is based;
3. A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered.

Within one hundred eighty (180) days after you receive notice that your claim has been denied, you or your representative may file a written request with the Claims Administrator appealing the denial and requesting review of it. You or your representative are entitled to review the pertinent documents and may also submit issues and comments in writing to be considered as part of the review.

<p><b>"Authorized Representative"</b> means a person entitled to act on your behalf and recognized by the Plan Administrator. In order to be recognized by the Plan Administrator, the person must have a completed "Authorized Representative Form" on file with the Claims Administrator.</p>
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The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial;
2. The specific Plan provision(s) on which the decision is based; and

3. A statement of your right to review (on request and at no charge) relevant documents and other information.

### **3.7 What if I am subject to a medical child support order?**

Notwithstanding any provision of the Plan to the contrary, the Plan shall recognize *Qualified* Medical Child Support Orders ("QMCSOs"). To be recognized, specific procedures must be followed. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the Plan Administrator. Participants, spouses or dependents may request from the Plan Administrator a copy of the Plan's QMCSO procedures (which will be provided at no charge).

### **3.8 Will I have any administrative costs under the Plan?**

The Employer pays the Plan set-up fee. The Employer pays the annual per participant fee of \$10 while participant is employed by Employer. Following separation of service, the participant pays the annual per participant fee of \$10.00. Per participant fees are paid quarterly. If Benny card is elected by participant, the cost is \$20.00 per year and is paid by the participant. Participant receives two cards for the \$20.00 fee. The Benny card is a voluntary option. The plan includes a fixed account option only and there is no asset based fee on the fixed account.

### **3.9 What happens to my HC Account if I die?**

If there is a balance in your HC Account at the time of your death, your spouse and dependent(s) *may* be able to continue to access these funds. See Section 3.10 below. Access to your HC Account is only available in the event such access is offered and selected as an alternative to any continuation coverage that may otherwise be available.

### **3.10 In what situations will the balance of my HC Account be forfeited?**

Amounts attributed to your HC Account shall be forfeited upon your death if you don't have a spouse and/or dependent(s). If participant passes away without a spouse or dependents, the Plan shall provide that the participant's estate/family members shall have 12 months after participant's passing to submit any final and remaining medical expenses incurred by the participant not previously reimbursed. After the 12-month time period any remaining funds shall be forfeited and placed in a forfeiture account. Any funds placed in a forfeited account may be used by the employer to pay Plan administrative fees or may be used to fund future contributions into the plan.

After separation from employment if an account remains inactive for five years, funds will be forfeited but only after reasonable attempts have been made to locate the participant of the account. Note: it is the intent of the employer to maintain this plan indefinitely; however, the employer has the right to terminate the plan. After all benefits and administrative fees are paid as outlined in the Plan Document forfeited funds may revert back to the employer.

## **Article IV. Investments**

### **4.1 What happens to the funds before I take them out?**

All assets of the Plan will be held in a trust by the Trustee. The Trustee will administer the trust in accordance with the Plan.

**"Trustee"** means Matrix Trust Company

Contribution made into your HC Account shall be directed to the fixed interest account.

**Caution:** Not FDIC insured. Earnings are not guaranteed. You may experience investment losses.

#### **4.2 Are the earnings taxable?**

No. The earnings accumulate on a tax-free basis. When the HC Account balance is accessed for reimbursement of a claim, there is no distinction between contribution dollars and earnings.

### **Article V. Continuation Coverage**

A Participant, and any others who are covered through that Participant, **may** be entitled to elect to continue coverage under the Plan in accordance with the Consolidated Omnibus Reconciliation Act of 1985, as amended ("COBRA"), or the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), as described below.

*Are there other coverage options besides COBRA continuation coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace (established by ACA), Medicaid or other group health plan options (such as a spouse's plan though what is called a "special enrollment period." It is possible that some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at <https://www.healthcare.gov/>.*

#### **5.1 What are my continuation rights under COBRA?**

Your Employer is not subject to COBRA **if** your Employer does not have twenty (20) or more employees. Should your Employer become subject to COBRA in the future, you will receive a detailed notice of your rights under COBRA.

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premiums for the continuation coverage.

This notice is intended to inform persons covered under the Plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. The Plan Administrator has developed additional policies regarding the provision of continuation coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

This notice covers only this Plan.

**Each person covered under the Plan should read this notice carefully.**

**Qualifying Events.** Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary."

**Qualifying event.** A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

**Qualifying beneficiary.** A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event were covered under the group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or placed for adoption with a qualified beneficiary *who was the employee* is a qualified beneficiary if he or she was covered under the group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provide coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

**Employee Loss.** If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

**Spouse's Loss.** If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

the employee's death; or

divorce or legal separation from the employee.

**Please Note:** If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

**Dependent Child's Loss.** If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

the employee's death;

divorce or legal separation of the employee and the child's other parent; or

the child ceasing to be a "dependent child" under the terms of the plan.

**Employer's Bankruptcy.** Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

**Responsibility to Notify.** In certain circumstances, you are required to provide notification to the Plan in order to protect your rights under COBRA.

Notice of Qualifying Event. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last of the sixty (60) day notice period described above. The notification must:

- (1) state the name of the Plan;
- (2) state the name and address of the employee or former employee who is or was covered under the Plan;
- (3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;
- (4) include a detailed description of the event;
- (5) identify the effective date of the event; and
- (6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no continuation coverage will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no continuation coverage will be provided.

You must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator, so that the Plan Administrator can determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you are unable to provide satisfactory evidence within thirty (30) days after a written or oral request from the Plan Administrator, the COBRA coverage may be terminated (retroactively if necessary) as of the date that COBRA coverage would have started. The Plan will require repayment to the Plan of all benefits paid after the termination date. Any COBRA coverage in effect for the individual who reported the qualifying event to the Plan also may be terminated.

Notice of Second Qualifying Event. In addition, the employee or a family member (or a representative acting on behalf of the employee or family member) must notify the Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above.

The notification must:

- (1) state the name of the Plan;

- (2) state the name and address of the employee or former employee who is or was covered under the Plan;
- (3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
- (4) identify the nature and date of the initial qualifying event that enabled the qualified beneficiaries to become subject to COBRA coverage;
- (5) include a detailed description of the second event;
- (6) identify the effective date of the second event; and
- (7) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided within thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

You must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator, so that the Plan Administrator can determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you are unable to provide satisfactory evidence within thirty (30) days after a written or oral request from the Plan Administrator, the COBRA coverage may be terminated (retroactively if necessary) as of the date that COBRA coverage would have started. The Plan will require repayment to the Plan of all benefits paid after the termination date. Any COBRA coverage in effect for the individual who reported the qualifying event to the Plan also may be terminated.

Notice of Disability. Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.) The notification must be provided in writing and be mailed to the Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The notification must:

- (1) state the name of the Plan;
- (2) state the name and address of the employee or former employee who is or was covered under the Plan;
- (3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of the notice;
- (4) identify the nature and date of the initial qualifying event that enabled the qualified beneficiaries to become subject to COBRA coverage;
- (5) state the name of the disabled qualified beneficiary;
- (6) identify the date upon which the disabled qualified beneficiary became disabled;
- (7) identify the date upon which the Social Security Administration made its determination of disability; and
- (8) include a copy of the determination of the Social Security Administration.

If no notification is received within the required time period, no extension of the continuation period will be provided. If the notification is incomplete, it will be deemed timely if the Plan is able to determine

the plan to which it applies, the identity of the employee and the qualified beneficiaries, the qualifying event, and the date on which the qualifying event occurred, provided that the missing information is provided with thirty (30) days. If the missing information is not provided within that time, the notification will be ineffective and no extension of the continuation period will be provided.

If such person has been determined under the Social Security Act to no longer be disabled, the person must notify the COBRA Administrator of that determination within thirty (30) days of the later of: (1) the date of such determination; or (2) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notice must be in writing and be mailed to the COBRA Administrator at the address identified below. Regardless of when the notification is provided, continuation coverage will terminate retroactively on the first day of the month that begins thirty (30) days after the date of the determination, or the end of the initial coverage period, if later. If you do not provide the notification within the required time, the Plan reserves the right to seek reimbursement of any benefits provided by the Plan between the date coverage terminates and the date the notification is provided.

**Failure to provide timely notification of a qualifying event ends the right to COBRA continuation coverage.**

**Election Rights.** When a qualifying event occurs, or when the COBRA Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the COBRA Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Because the Employer and the Plan Administrator are the same entity, the COBRA Administrator has forty-four (44) days to provide the option to elect COBRA coverage. Under the law, qualified beneficiaries have at least sixty (60) days to elect continuation coverage measured from the later of (1) the date coverage would be lost because of a qualified event, or (2) the date a notice of election rights is provided. An election is considered "made" on the date sent. If continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If continuation coverage is not elected within this period, coverage under the Plan ends.

Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

**Please Note:** Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

**Duration.** The law requires that qualified beneficiaries generally be allowed to maintain continuation coverage as follows:

**Eighteen (18) Months.** If the qualifying event is the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment, the continuation period is eighteen (18) months measured from the date of the qualifying event.

**Disability Extension.** For qualified beneficiaries receiving continuation coverage because of the employee's termination or reduction in hours, the continuation period may be extended eleven (11) months, for a total maximum of twenty-nine (29) months where a qualified beneficiary receives a determination under the Social Security Act that at the time of the employee's termination of employment or reduction of hours, or within sixty (60) days of the start of the eighteen (18) month continuation period, the qualified beneficiary was disabled. The extension is available to all qualified beneficiaries in the family group.

**Pre-Qualifying Event Medicare Extension.** The eighteen (18) month continuation period may be extended if the employee became entitled to (actually covered under) Medicare prior to the employee's termination of employment (other than for gross misconduct) or a reduction in hours. Qualified beneficiaries other than the employee are entitled to the greater of (1) eighteen (18) months measured from the qualifying event or (2) thirty-six (36) months measured from the date of the employee's Medicare entitlement.

**Thirty-Six (36) Months.** For qualifying events other than termination of employment (other than for gross misconduct) or a reduction in hours, the continuation period is thirty-six (36) months measured from the date of the qualifying event.

**Second Qualifying Events.** If during the initial eighteen (18) month continuation period (or during an extension of that period for disability or for pre-termination Medicare entitlement) a second qualifying event occurs (e.g., divorce or legal separation, death of employee, loss of dependent status) that would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred, the continuation period for the particular qualified beneficiaries affected by the second qualifying event may be extended to thirty-six (36) months.

Under no circumstances may the total continuation period be greater than thirty-six (36) months from the date of the original qualifying event that triggered the continuation coverage.

**Type of Coverage.** Initially, the coverage will be the same coverage as immediately preceding the qualifying event. Thereafter, coverage must be identical to the coverage provided to similarly situated employees or family members that have not experienced a qualifying event. In addition, special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") will apply to those who have elected COBRA.

**Cost.** A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18<sup>th</sup>) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

**Pre-Mature Ending.** The law provides that continuation coverage shall automatically end for any of the following reasons:

the Employer no longer provides group health coverage to any of its employees;

the premium for continuation coverage is not paid on time (including any applicable grace period);

with respect to disability extension coverage, a final determination that the qualified beneficiary is no longer disabled; or

**Please note:** This cuts short the coverage for all qualified beneficiaries with extended coverage.

termination for cause under the generally applicable terms of the group health plan (e.g., submission of fraudulent benefit claims).

**Insurability.** A qualified beneficiary does not have to demonstrate insurability to elect continuation period.

**Trade Act of 2002.** Pursuant to the Trade Act of 2002, certain employees and former employees who are receiving trade adjustment assistance ("TAA") may be eligible for a special second COBRA election

and a tax credit for premiums paid for continuation coverage. TAA is generally available to those employees who have lost their jobs or suffered a reduction in hours because of import competition and shifts in production to other countries. If you are potentially eligible for these rights under the Trade Act, you will receive additional information regarding it at the time of your qualifying event.

**Address Changes:** Important information is distributed by mail. In order to protect your family's rights, if a qualified beneficiary's address changes, the qualified beneficiary or someone on its behalf should notify the Plan Administrator immediately.

**More Information:** The Employer has hired a third party to administer COBRA or The Employer administers its own COBRA responsibilities. The Employer has hired a third party to administer COBRA. All questions, notices, and other communications regarding COBRA and the Plan should be directed to:

Employer Benefit Administrators, LLC  
3125 Airport Parkway N.E.  
Cambridge, MN 55008  
Phone number: 888-507-6053

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

## 5.2 [What if I just want to spend down my account?](#)

Following termination of employment, the Plan allows you to spend down the balance of your HC Account if you choose to continue to access your HC Account in lieu of COBRA continuation coverage. If you choose to spend down your HC Account, you may generally continue to submit claims for eligible Health Care Expenses until the earlier of: (i) the date the account balance reaches zero, or (ii) the fifth (5<sup>th</sup>) anniversary of the date of the termination of your employment if the account has been inactive for five years but only after reasonable attempts have been made to locate the account holder.

Upon your death, your surviving Spouse and Dependents will be allowed to spend down the balance of your HC Account if they choose to continue to access your HC Account in lieu of COBRA continuation coverage. If they choose to spend down your HC Account, your surviving Spouse and Dependents may generally continue to submit claims for eligible Health Care Expenses until the account balance reaches zero. (See Section 3.9 regarding other situations in which such access may terminate.)

## 5.3 [What are my continuation rights under USERRA?](#)

USERRA requires all employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services.

This notice is intended to inform persons covered under a group health plan, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your U-continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the USERRA Administrator.

This notice covers this Plan only.

**Each person covered under the Plan(s) should read this notice carefully.**

**Service Leave Event.** If covered by any of the group health plans described above, the employee has the right to elect U-continuation coverage for him/herself and his/her dependents if they lose coverage under such plan due to an absence from employment for service in the uniformed services (a "service leave").

**Service in the Uniformed Services.** Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

**Election Rights.** You have sixty (60) days to elect U-continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An election is considered "made" on the date sent. If U-continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If U-continuation coverage is not elected within this period, coverage under the Plan ends. However, if the no election is made in a situation in which you are not required (in accordance with USERRA) to provide advance notice of your service (e.g., because such notice was impossible, unreasonable, or precluded by service necessity), your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

**Note:** Your dependents with coverage under the Plan(s) do not have an independent right to elect U-continuation coverage. Their coverage may be continued only if you elect U-continuation coverage.

**Duration.** The law requires that you generally be allowed to maintain U-continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

**Type of Coverage.** Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated employees or family members that are not on service leave.

**Cost.** A person electing U-continuation coverage may have to pay all or part of the cost of U-continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the plan of providing the coverage.

Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of within which to make the payment. The length of the grace period will be thirty days (30).

**Termination of the Continue Coverage.** The U-continuation coverage may be terminated for any of the following reasons:

- the Employer no longer provides group health coverage to any of its employees;
- the premium for U-continuation coverage is not paid on time (including the grace period);

your failure to return from service or apply for a position of employment as required under USERRA;  
or

termination for cause under the generally applicable terms of the group health plan (e.g.,  
submission of fraudulent benefit claims).

**More Information:** For information about USERRA, you may contact the District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## **ARTICLE VI. FAMILY AND MEDICAL LEAVE ACT OF 1993**

### **Family and Medical Leave Act of 1993 ("FMLA")**

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. Should your Employer have more than fifty (50) employees, this Plan (including the component plans) shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. If your Employer is subject to FMLA, then you should be provided with a complete explanation of FMLA rights and responsibilities. Contact your Employer if you have questions about FMLA.

Also, note that the **Newborns' and Mothers' Health Protection Act ("NMHPA")** applies to the Plan. Under NMHPA, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issues may not require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Contact the Plan Administrator if you have questions about NMHPA and its application to this Plan.

### **COBRA and HIPAA Rights.**

As a Participant in the Plan you may be entitled to continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

**Small Employer Exception:** The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with *twenty (20) or more employees* to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. However, your Employer is currently too small in size for COBRA coverage to apply.

### Prudent Actions by Plan Fiduciaries.

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

### Enforce Your Rights.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. To the extent ERISA applies, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor (or other applicable agency should ERISA not apply), or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### Assistance with Your Questions.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA (as applicable) or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Plan Administrator:** Your Employer is the Plan Administrator. EBC/EBA is the Claims Administrator and acts as your Employer's designee. All notices and other communication should be directed to:

Employer Benefit Administrators, LLC  
3125 Airport Parkway N.E.  
Cambridge, MN 55008  
Phone number: 888-507-6053

## **ADMINISTRATIVE INFORMATION**

### **Plan:**

Plan Name:	City of Burlingame Post-Employment Health Reimbursement Arrangement
Plan Type:	Post-Employment Health Reimbursement Arrangement
Plan Number:	
Plan Year (Start to End)	July 1-June 30
<b>Effective Date of Plan</b>	November 1, 2016
<b>Date of this SPD</b>	November 1, 2016

### **Employer & Plan Administrator:**

Name:	City of Burlingame
Address:	501 Primrose Road
City, State Zip:	Burlingame, CA 94010
Phone Number:	650-558-7206
EIN:	94-6000304
Contact Person:	Lisa K. Goldman

### **Agent for Service of Legal Process:**

Name:	City of Burlingame HR Director
Address:	501 Primrose Road
City, State Zip:	Burlingame, CA 94010
Phone/Fax Number:	650-558-7206; Fax 650-340-0331

### **Claims Administrator:**

Name:	EBA
Address:	3125 Airport Parkway NE
City, State Zip:	Cambridge, MN 55008
Phone Number:	Toll-Free 888-507-6053; Metro: 763-552-6053
Fax Number:	763-552-6055

### **Directed Trustees:**

Name:	Matrix Trust Co.
Address:	717 17 <sup>th</sup> St. Suite 1300
City, State Zip:	Denver, CO 80202
Phone Number:	877-610-3822